ABSTRACT

Hope for Recovery: Correlations Among Codependency, Internalized Shame, and Spiritual Well-Being

by

Paul D. Fitzgerald

"Can the church utilize a twelve--step support group to be a healing community to those who find the codependency paradigm a meaningful way to describe their emotional pain and spiritual struggle?" The review of literature traced the development of codependency as a multidimensional psychosocial construct characterized by dysfunctional relationship patterns that is correlated positively with internalized shame and negatively with spiritual well-being. Participation in twelve--step groups was prescribed as a way to find recovery. The literature review included shame as a psychological construct, shame themes in the Bible, and spiritual well-being.

New Hope for Recovery, a twelve--step support group ministry of College Church of the Nazarene, Olathe, Kansas, was the research population. A comparison population was selected from the attendance of the same church.

Using a quasi-experimental, nonrandomized control group pretest posttest design, the study identified changes in codependency, internalized shame, and spiritual well-being over an eighteen month period. The independent variable was identified as participation in New Hope for Recovery. Data were analyzed utilizing nonparametric methods.

The research group was significantly different from the comparison group at pretest, having higher codependency, higher internalized shame, and lower spiritual well-being. Consistent with the goal of recovery, the research group experienced a significant decrease in codependency and an increase in degree of spiritual well-being between pretest and posttest measurements. Changes in internalized shame were less consistent: 1) the comparison group's posttest mean score increased 128 percent; 2) part of the research sample experienced a significant increase in internalized shame that was positively correlated with involvement in New Hope for Recovery. Codependency and internalized shame were positively correlated while both were negatively correlated with spiritual well-being. The nature of recovery was discussed as "second-order" and "reframing" change.

The study concludes that the New Hope model attracts codependents and offers a healing community in which issues of codependency, internalized shame, and spiritual well-being can be addressed. The author calls for research on shame as a missing paradigm in biblical and theological studies.

DISSERTATION APPROVAL

This is to certify that the dissertation entitled

HOPE FOR RECOVERY: CORRELATIONS AMONG CODEPENDENCY, INTERNALIZED SHAME, AND SPIRITUAL WELL-BEING

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HOPE FOR RECOVERY: CORRELATIONS AMONG CODEPENDENCY, INTERNALIZED SHAME, AND SPIRITUAL WELL-BEING

A Dissertation

Presented to

the Faculty of Asbury Theological Seminary

In Partial Fulfillment

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DOCTOR OF MINISTRY

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FACULTY'S DISTINGUISHED DISSERTATION AWARD

FOR

EXCELLENCE IN RESEARCH IN PASTORAL MINISTRY

The Faculty of Asbury Theological Seminary this year has chosen to bestow a "Distinguished dissertation Award for Excellence in Research and Pastoral Ministry" upon Paul D. Fitzgerald. This award recognized and honors at Commencement a Doctor of Ministry graduate who submits the outstanding dissertation-project for that year.

In order to receive the award, the graduate's dissertation must,

1. Contribute in a substantial way to the Church's understanding of the nature and practice of ministry.
2. Demonstrate potential for publication.
3. Consistently follow standard conventions for social science research where applicable, and
4. Conform uniformly to designated style and guidelines in all respects.

Paul's dissertation, entitled "Hope for Recovery: Correlations among Codependency, Internalized Shame, and Spiritual Well-Being," meets and exceeds these criteria. The Faculty congratulate both Paul and his faculty mentor, Dr. J. Steven Harper, on this outstanding achievement.

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ACKNOWLEDGEMENTS

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CHAPTER 1: UNDERSTANDING THE PROBLEM

Introduction to the Problem

In addition to spiritual counseling, marriage and family counseling, divorce counseling, grief counseling, and, situational adjustment counseling, the church is becoming aware of the special emotional and spiritual needs of many individuals within the church who are identified as codependents. Hemfelt, London and Wiseman, Rinck, and others note that the pastoral care and spiritual formation needs of the contemporary church are overwhelming the structures and pastoral care resources of the traditional church. Wilson's study of Evangelical Adult Children of Alcoholics found that they present emotional and spiritual symptomology as struggling with a sense of self that is characterized by shame that has been internalized as feelings of rejection, worthlessness, and as unlovable. These internalized feelings affect their confidence that they can trust God to be forgiving.

For some codependents psychosocial functioning is impaired to the point that the church must become a referral source for professional counseling services. Even when referral is appropriate, Wilson points out that the church's role in the codependent's soul care continues during and after therapy. Many codependents do not require referral yet they struggle with substantial barriers to effective psychosocial functioning and healthy spirituality. If the

church is to provide for their soul care, addressing the special emotional and spiritual needs of this population must be a critical part of the church's ministry.

Codependency is a contemporary paradigm effectively defining the pastoral care needs of many who look to the church for emotional support and spiritual assistance. Arterburn, Hemfelt, Rinck and others note that the presenting issues range from a general dissatisfaction with life and spirituality to specific issues, including: childhood abuse, substance or process addictions, or difficult choices related to current dysfunctional relationships with family and friends.

While much of the literature of codependency is based on clinical observations, some empirical research has been reported. No definition of codependency is universally accepted, consequently the literature includes a variety of definitions and descriptions. Much of the earliest literature linked codependency to relationships with an alcoholic. More recent literature expanded the link to being an adult child of an alcoholic. More recent literature expands the paradigm, suggesting that codependent behavior is related to the experience of living in any dysfunctional family without regard to the presence of alcoholism (Friel and Friel "Excellent Word"; Gromberg; Meacham; Shulman).

Clinical observations about codependents commonly include the presence of shame that has been internalized as

well as the absence of spiritual well-being. Fossom and Mason, Mellody, Seixas and Youcha, Potter-Efron, and others report codependents as shamed and humiliated by the abuse and neglect in their family-of-origin. Often the public behavior of other family members was a source of shame, leaving them feeling powerless as the shameful behavior was outside their control. Codependents report seeing themselves as defective and inadequate, having low self-esteem, and experience self-hatred. Survival skills such as denial, dissociation, hyper-vigilance, and caretaking learned in their dysfunctional family become their normal way of relating to others. These behaviors are learned in childhood and continue to be used in adult life resulting in relationship failures and reinforces the codependent's internalized self-concept of shame.

Codependents frequently report spiritual difficulties. Arterburn, Bradshaw, Mellody, and Wilson note that abuse and neglect robs a child of self-worth that would affirm that they are positively unique, valuable, and worthy of the unconditional love of God. They perceive themselves as defective, without value, unlovable, and deserving to be abandoned by God. Their defensive use of vigilance to protect themselves from further abuse and shaming as well as their persistent self-identity as victims damages their ability to trust and to experience the mutuality of community--a core component in healthy spirituality. Abuse and

neglect by parents or other significant adults portrays an image of God as cruel, punishing, untrustworthy, and ready to abandon them without provocation.

Recovery from codependency may require professional counseling, however treatment recommendations consistently include participation in a twelve-step support group that exposes the individual to the spiritual healing process embodied in the Twelve Steps of Alcoholics Anonymous. Schaef offers the opinion that, "Recovery from the disease of co-dependence is impossible without recognizing and working with spiritual issues as healing issues" (Co-Dependence 92). Twelve-step support groups represent the fastest growing spiritual healing movement in America, having an estimated 500,000 weekly meetings with some 15 million in attendance (Leerhsen et al. 50-55; Andrews 144-156). The source of the spiritual healing process embodied in the Twelve Steps of Alcoholics Anonymous is found in their link to the Oxford Group Movement, an evangelical spiritual renewal movement founded by Frank Buchman.

Buchman, a Lutheran Minister, founded the Oxford Groups to nurture a pietistical spirituality based on the practice of absolute honesty, absolute purity, absolute unselfishness, and absolute love. The four absolutes were derived from his understanding of the teachings of Jesus in the Sermon on the Mount. They were embodied in ten steps that each member was encouraged to practice with the support of

the small group. The core of the Twelve Steps of Alcoholics Anonymous is clearly derived from the biblically-based ten steps of the church-based Oxford Group, however their healing potential has generally been transparent to the church community (Shoemaker et al.).

This research project grew out of the author's personal journey through recovery from work addiction and the discovery of personal issues of codependency, internalized shame, and their impact on spiritual well-being. Fifteen years of compulsively searching for self-worth and affirmation through work in denominational administration led to *hitting the bottom* and nearly dying from physical exhaustion and total neglect of personal health. At the time of the crisis no one offered the observation that the real *dis-ease* was work addiction. However, denial of the problem was broken in ways that would no longer allow it to be hidden. It became obvious that past personal choices had been inflicting painful consequences on myself, my family, and my spirituality. Yet, work and worshipping support systems lacked a paradigm to point the way to full recovery beyond the physical recuperation needed to "get back to work again." While sympathetic, the church community's encouragement did not challenge the patterns of compulsive work and external search for affirmation.

The painful acknowledgement of guilt over the consequences of past personal behavior naturally led to seeking

forgiveness from those hurt by selfish choices and changes in behavior. Yet, setting healthy boundaries and limits at work resulted in new guilt feelings over not working *hard enough*, creating a double bind in the form: "Unless I reduce work commitments to care for relationships I am selfish, yet not working hard enough for God is also selfish."

A change in ministry assignment to a staff position in the local church led to increased pastoral counseling. This resulted in increased frustration with the traditional forgiveness/commitment solutions that I had been trained to offer. The majority of these counselees were *believers* with non-pathological spiritual formation challenges that appeared to be rooted in compulsive self-defeating patterns of behavior or beliefs about their personal worth. The traditional formula of more faith, forgiveness, Bible reading, Scripture memorization, church attendance, and ministry service offered little help.

Personal discovery of the concepts of codependency, work as a process addiction, internalized shame, and the twelve--steps as a spiritual formation process, led to a personal paradigm shift in understanding God's grace and to a new theology of ministry--recovery as a spiritual formation process. It was confusing to try to share this new frame of reference with others involved in professional ministry; almost as if speaking a strange language. Yet it was a language commonly shared by professionals involved in

addiction recovery programs as well as the program participants.

Contemplating the struggle in communicating this new understanding of grace and ministry, I was suddenly struck with the prominence that shame played in the literature of recovery and its absence from my theological language. A grace-filled happenstance led to a book by Lowell L. Noble, Naked and Not Ashamed, that provided an important link to the literature of shame and probing questions about its absence from biblical and theological studies.

This research is part of a personal and professional journey to share this new paradigm and theology of ministry with the church and with those whose spiritual formation has been similarly impacted by the issues of codependency and internalized shame.

The church is called to be a healing community where all can find deliverance, freedom, nurturing, meaningful service, soul care, a worshiping community, and love that is totally incompatible with the fear of shame. Faced with the overwhelming number of adults who find codependency describing the painful barrier to their healthy spiritual and psychosocial functioning, the question must be asked: "Can the church utilize a twelve-step support group to be a healing community to those who find the codependency paradigm a meaningful way to describe their emotional pain and spiritual struggles?"

Context of the Problem

College Church of the Nazarene is located in Olathe, Kansas, a rapidly growing suburban community of approximately 65,000, adjacent to metropolitan Kansas City. Dr. Paul G. Cunningham, Senior Pastor since 1964, was the supervising pastor during this study. The church had nine full-time ministry staff members, an average weekly worship attendance of 2000, and church membership of slightly more than 2000.

New Hope for Recovery is an adult support group ministry of College Church that utilizes a small group format and the Twelve Steps of Alcoholics Anonymous adapted to apply to codependency recovery. New Hope is open to the community without cost to participants. Attendance of College Church's worship services is welcomed but not required for participation in New Hope. The New Hope brochure describes the target audience as follows:

> New Hope is a 12-Step support ministry sponsored by College Church of the Nazarene to support recovery from codependency, divorce, substance abuse, long-term effects of sexual abuse, and dysfunctional families. Participation is designed to complement professional counseling and other support groups. If you grew up in an abusive home, a home that had an addicted member, or a dysfunctional family; if you have been affected by addictions or abuse in your life or family, you can benefit from New Hope. Members have experienced anger, a sense of lacking personal worth, inability to sustain personal relationships and frustration in attempting to live as a child of God.

New Hope for Recovery began in September 1989 as an effort to meet the soul care needs of the growing, self-identified codependent population. New Hope, while adapting the Twelve Steps of Alcoholics Anonymous, is intentionally designed not to be an issue-specific group (in contrast to other issue-specific groups such as Alcoholics Anonymous, Narcotics Anonymous, or Codependents Anonymous) in order to avoid any sense of competition with already established issue-specific support groups. New Hope is structured to complement concurrent participation in professional counseling or other support groups while providing a healing and nurturing environment to work on recovery and spirituality within the church community. Weekly adult attendance at New Hope averaged 125 adults at the beginning of this study. In addition, New Hope provides basic child care and a small group program for the elementary age children of New Hope participants to help the children build self-esteem and learn new coping skills.

Purpose of the Inquiry

The purpose of the proposed study is to assess changes in and correlation among codependency, internalized shame, and spiritual well-being over time in certain participants in New Hope for Recovery, a twelve-step ministry of College Church of the Nazarene, Olathe, Kansas.

Rationale Underlying the Study

Codependency, internalized shame, and spiritual well-being are conceptualized as measurable along a continuum from low to high degree. Changes along the continuum, resulting from some intervention, should be measurable by using standardized research instruments as pretests and posttests before and after the intervention.

Using a quasi-experimental, nonrandomized comparison group pretest posttest design, this study identified changes and correlations of changes in degree of codependency, degree of internalized shame, and degree of spiritual well--being in a convenience sample of participants in New Hope for Recovery and a nonrandomized comparison group resulting from the intervention experienced by participants in New Hope for Recovery.

New Hope for Recovery has three distinct phases with additional support for participants upon completion of the formal program. Upon completion of the four-session Orientation Group participants may continue by participating in an Open Group. The Open Group phase consists of twenty-five weekly sessions in small groups that have open membership from week to week. Open Groups are leaderless but follow a guide for structuring discussion. Upon completion of the Open Group phase, participants may apply to join in a Covenant Group. The Covenant Group phase utilizes a thirty-session writing-intensive workbook based on the Twelve Steps

of Alcoholics Anonymous with biblical support. It has a closed membership and operates as a leaderless small group. Appendix A includes a general description of the New Hope for Recovery program.

The New Hope sample included participants entering the Open Group phase or the Covenant Group phase who volunteered during the four-week period preceding the administration of the pretest. The nonrandomized comparison group consisted of adult volunteers from the population of those who attend the Morsch/Brower Sunday School Class at College Church of the Nazarene but who did not attend New Hope for Recovery. The same instruments were administered as a posttest to all groups after approximately eighteen months.

Population and Sample

Population. New Hope for Recovery, the research population, had an average weekly attendance of 125 adults at the beginning of this study. New participants entered the program each week as the result of referral by counselors, pastors, friends, as well as in response to announcements in newspaper, radio, church bulletin and church newsletter.

The Morsch/Brower Class, the largest adult Sunday School class in College Church, had an average weekly attendance of 125 adults at the beginning of this study. Volunteer participants from this class were the comparison population for this study.

Sample. The original sample, i.e. all participants who completed the pretest instruments, included: 30 New Hope participants who entered the Open Group Phase during the four-week period prior to the administration of the pretest, 23 New Hope participants who entered the Covenant Group phase during the four-week period prior to the administration of the pretest, and 32 participants in the comparison population who completed the pretest during the same four-week time period.

The research sample, i.e. all participants who completed the pretest and posttest instruments, included: 14 New Hope Open Group participants, 14 New Hope Covenant Group participants, and 10 from the comparison population.

The mortality sample, i.e. all participants who completed the pretest instruments but did not complete the posttest instruments, included: 16 Open Group participants, 9 Covenant Group participants, and 22 from the comparison population.

Significance of the Study

The significance of the study is the documentation of clinically based observations of the relationships among codependency, internalized shame, and spiritual well-being as well as predicted changes in the their presence consistent with participation in a codependency recovery program utilizing a twelve-step support group. No other research has been identified that attempts to correlate degree of

codependency, internalized shame, and spiritual well-being in a codependent population or to measure the correlation of changes in these factors in codependency recovery.

Statement of Research Questions

The following research questions are addressed in this study, including an analysis of outside variables that may contribute to or explain changes between the pretest and posttest scores.

Research Question 1

What are the changes and correlations of changes in degree of codependency within the samples in the study?

Research Question 2

What are the changes and correlations of changes in degree of internalized shame within the samples in the study?

Research Question 3

What are the changes and correlations of changes in degree of spiritual well-being within the samples in the study?

Research Question 4

What are the correlations of changes in codependency, internalized shame, and spiritual well-being within the samples in the study?

Definition of Terms

This section will provide an operational definition for each of the following terms:

ACOA Adult Children of Alcoholics designates adults who lived as children with at least one alcoholic parent and were psychosocially affected by that experience. Ackerman and Gondolf estimate this to be 20 million adults in the US.

ACDF Adult Children of Dysfunctional Families designates adults who lived as children in a family that used dysfunctional communication rules (Friel and Friel 75). Much of the research has failed to clearly distinguish between being an ACOA or an ACDF (Benson and Heller; Harrison; O'Farrell and Bircher; Prest and Storm).

Codependency While no universally agreed upon definition exists, in this study it means a "psychosocial condition that is manifested through a dysfunctional pattern of relating to others. This pattern is characterized by: extreme focus outside of self, lack of open expression of feelings, and, attempts to derive a sense of purpose through relationships" (Spann and Fischer 27). This definition assumes that the patterns of codependency range on a continuum from low degree to high degree.

Comparison Group The participants in this study who volunteered from the Morsch/Brower Sunday School Class, the largest adult class at College Church of the Nazarene. None of the comparison group attended New Hope for Recovery before or during this study.

Covenant Group The third phase of the New Hope for Recovery ministry. Completion of the second phase Open

Group is required for participation in a Covenant Group. Covenant Groups are leaderless, closed, small groups of men or women who utilize the structure of a twelve-step writing-intensive workbook for their weekly sessions.

Guilt The awareness of having committed an offense, crime, or violation of a legal or moral norm as distinguished from shame. To become guiltless, the guilty person must suffer punishment, make restitution, or be forgiven.

Internalized Shame A self-schema of low self-worth, self-judgement as inferior, and the anticipation of continued exposure of one's defects and consequent abandonment by others. Frequent and repeated experience of shame affect and shame emotion with inadequate amelioration by caregivers form the basis of an internalized shame self-schema.

New Hope for Recovery A support group ministry of College Church of the Nazarene, Olathe, Kansas, that uses the Twelve Steps of Alcoholics Anonymous as adapted to various issues including codependency. New Hope for Recovery is a multi-issue support group in that individuals do not have to identify a particular issue such as alcoholism or drug addiction to participate. The only requirement is a willingness to participate in the group process.

Open Group The second phase of the New Hope for Recovery ministry. Completion of the first phase Orientation Group is required for participation in an Open Group. Open Groups are leaderless, open, small groups of men and women

who utilize discussion guides for weekly sessions.

Orientation Group The first phase of the New Hope for Recovery ministry. Participation is open to the community. Sessions include video presentations, lectures, and dyad discussions.

Recovery A term used to denote improved psychological, social, spiritual, and physical well-being and integrated functioning of all the human subsystems.

Shame A multi-dimensional term used to refer to a complex cluster of painful and negative experiences i.e. feeling inferior, defective, alienated, unworthy, incompetent, empty, and/or self-contempt. Shame includes the fear of exposure of the internalized shame-based *reality* and one's ideal. At the same time, shame is a positive good and fundamental to healthy identity formation, moral judgement, and the experience of spirituality. Shame feelings are expressed phenomenologically by expressions such as, "I just wanted to die" and "I wanted to disappear through a hole in the floor." The physical experience of shame includes blushing, loss of body tonus, and lowering of the eyes to avoid exposure of face.

Spiritual Well-Being A holistic concept of well-being as the integrated functioning of human emotional, physical, cognitive, and spiritual subsystems. Conceived as a combination of Religious Well-Being and Existential Well-Being Ellison contrasts the experience of psychospiritual integra-

tion with intrapsychic or interpersonal conflicts that lead to emotional turmoil, mental illness, fragmentation, distress, and, disintegration. He finds precedence for the term in the biblical concept of shalom as the experience of a person "functioning as God intended, in consonant relationship with Him, with others, and within one's self." Ellison's construct suggests that while shalom cannot be fully experienced because of the Fall of humanity, higher degrees of spiritual well-being can be realized "to the extent that the various subsystems are functioning harmoniously, consistently with the divine design of creation" (Ellison and Smith 36-37).

Methodology

This study utilized a quasi-experimental, nonrandomized comparison group pretest--posttest design, requiring various methodological issues to be addressed.

Variables

The independent variable in this study was participation in the New Hope for Recovery group. The dependent variables measured in this study included codependency, internalized shame, and spiritual well-being. The study controlled for extraneous variables including: age, sex, marital status, religion, education, pre-age eighteen parental alcohol abuse, pre-age eighteen parental death, pre-age eighteen parental divorce or permanent separation, pre-age eighteen experience of two or more months in a foster home.

Participants self-reported their behavior during the study on participation in the New Hope group, participation in other twelve step groups, participation in group or individual counseling, inpatient psychiatric treatment, changes in church worship attendance, changes in church attended, and intentional changes in spiritual practices i.e. Bible reading, prayer, meditation, journaling, fasting, others.

Instrumentation

The following instruments were used to operationalize the variables in this study:

The Spann-Fisher Codependency Scale (SFCS). SFCS was developed out of a literature review of clinical observations of the characteristics of codependents that resulted in a definition of codependency as a, "psychosocial condition that is manifested through a dysfunctional pattern of relating to others. This pattern is characterized by: extreme focus outside of self, lack of open expression of feelings, and, attempts to derive a sense of purpose through relationships" (Spann and Fischer 27). SFCS assumes that the characteristics of codependency range on a continuum from low to high with the high range identified with greater psychosocial dysfunction and uses a sixteen-item questionnaire using a six-point Likert-type scale for response to measure codependency (Spann, Fischer, and Crawford 100).

The Internalized Shame Scale (ISS). Cook's research on shame identified clinical observations on the negative

emotional impact of having excess shame, suggesting that the experience of too much shame has variable dimensions of frequency and intensity. His clinical observations link excess shame to experiences of rejection in family-of-origin, significant losses in family-of-origin, and the use of addictive behaviors as defenses against painful feelings of shame. The use of addictive behaviors becomes an additional source of and reinforcement of shame. These experiences appear to influence the formation of a shame identity based on the internalization of shame. The conceptualization of having an internalized shame self-schema is distinguished from the experience of shame affect and shame emotions that are consistent with healthy psychosocial functioning ("Addictions"). Cook's current version of the ISS is a thirty-item questionnaire using a five-point Likert-type scale for response to measure internalized shame. ISS has an embedded self-esteem scale using six of the ten items in the Rosenberg Self Esteem Scale. Cook reports that factor analysis of the Shame scale, the twenty-four remaining items, suggests two subscales identified as measuring "inferiority" and "alienation." The ISS instrument includes items to collect data on the outside variables for this study (Manual 1).

The Spiritual Well-Being Scale (SWBS). SWBS was developed in response to the absence of a measure of transcendence in the search for measuring subjective well-being.

Ellison suggests that the "need for transcendence" is one of several basic needs that must be satisfied for there to be an experience of subjective well-being. "This refers to the sense of well-being we experience when we find purposes to commit ourselves to which involve ultimate meaning for life. It refers to a non-physical dimension of awareness and experience which can best be termed spiritual" ("Conceptualization" 331).

The instrument consists of a twenty-item questionnaire using a six-point Likert-type scale for response. In addition to the overall Spiritual Well-Being (SWB) score, the items divide into two subscales measuring Religious Well-Being (RWB) and Existential Well-Being (EWB). All three scores assume that these are measures of continuous variables rather than dichotomous. Ellison qualifies the instrument as not measuring "spiritual health," or "spiritual maturity" (Ibid. 330-332).

Procedures

The research design was a quasi-experimental, nonrandomized comparison group pretest--posttest of the Open Group and Covenant Group phases of New Hope for Recovery and a Comparison Group. All new participants in New Hope for Recovery were required to participate in a four-session Orientation Group before entering the Open Group phase. Ideally the research sample would have completed the pretest before participation in the Orientation Group, however, it

was determined that introduction of the pretest before the Orientation Group sessions might discourage participation in the New Hope ministry. Participants who entered the Open Group or Covenant Group or who attended the Morsch/Brower Sunday School class during the four-week period prior to the administration of the pretest were requested to voluntarily participate in the study. Approximately eighteen months after the administration of the pretest, the same instruments were administered as a posttest. Volunteers from the comparison population took the same instruments as a pretest and posttest with the same eighteen months between tests.

Participants were to code their individual pretest and posttest instruments to allow for analysis of individual results as well as group results. Participation was voluntary with individual anonymity promised. The data were compiled and results analyzed and reported as the basis of this dissertation.

Data Analysis

Data resulting from the pretests and posttests were analyzed using nonparametric methods included in the Statistical Package for the Social Sciences (SPSS/PC+).

Delimitations and Generalizability

The setting of the research did not allow the use of a true experimental research design. A quasi-experimental, nonrandomized comparison group pretest-posttest research design was used, however this introduced limitations to the

results and their generalizability beyond the samples in this study.

While the design was unlikely to be influenced by the sample's aging between pretest and posttest, the results were limited by the introduction of the test instruments and by the experience of taking the instruments for pretest and posttest. The New Hope Group population was assumed to be characterized as having high need for external approval and for pleasing others, thus social desirability may influence the results.

All research participants were offered individual feedback from their individual results as measured by the research instruments following the end of the research period. However, this may have introduced a motivation to stay in New Hope for Recovery beyond the point they would otherwise have dropped out.

Limitations due to statistical regression were controlled for in the statistical analysis by eliminating extreme scores, however the test samples may represent extremes since they were convenience samples. Lack of controls for other extreme sample characteristics, e.g. reading disability, psychotic conditions, mood disorders, developmental disorders, intelligence quotients, extreme childhood ritual abuses, presence of or changes in medications, life crises (i.e. separation, divorce, remarriage, grief) or active suicidal ideation, may have limited the results of

this study and its generalizability.

Limitations on the correlation of measured changes due to research mortality were controlled for by eliminating the pretest results for any in the samples who did not take the posttest.

Overview of the Study

Chapter One of the study defines the purpose of the research; specifies the research questions, variables, population, sample, research design, instrumentation, analysis of the data; and, suggests the delimitation and generalizability of the results.

Chapter Two reviews selected research literature on codependency, shame, and spiritual well-being as well as shame themes in the Old and New Testaments. Secondary and clinically based literature are included where the observations inform the theoretical framework of the study.

Chapter Three presents the design of the study suggesting the basis for the selection of particular instruments to measure codependency, internalized shame and spiritual well-being. The methodology of the research, its implementation, and the methodology of statistical analysis are documented.

Chapter Four presents the formal data analysis and significant findings as a result of the study.

Chapter Five summarizes the findings of the study and suggests conclusions of the study, identifies the study's

limitations and generalizability, and proposes additional research possibilities suggested by this study.

CHAPTER 2: REVIEW OF SELECTED LITERATURE

Review of Selected Codependency Literature

Tracing the development of the codependency construct is complicated by its simultaneous emergence from several divergent paradigms, including: the co-alcoholic model of addiction, family systems theory model, the personality disorder model, and the wounded-self developmental model. The literature on codependency is primarily based on clinical observation and descriptive studies. Recent bibliographies (Ackerman and Michaels; Page; Windle) and Whitfield's efforts to document the history of codependency in Co-dependence: Healing the Human Condition suggests the explosive growth of interest in the codependency construct in the last two decades. Unfortunately few research studies have attempted to measure the presence of codependency or to measure changes resulting from a therapeutic intervention. This review of selected literature on codependency will identify key streams of thought contributing to the still emerging construct.

The Co-Alcoholic Model of Codependency

As early as 1944 Roe observed that living with an alcoholic parent impacted children into adult life. The impact on family members who had lived with an alcoholic parent were the subject of various qualitative studies and clinical observations over the following forty years (Fox; Globetti; Jackson; Krimmel; Meeks and Kelly; Scott). A

consistent theme throughout these studies is the prevailing view that alcoholism is a family disease.

The concept that living with an alcoholic potentially has long term emotional consequences for other family members was brought to the public's attention in 1969 in Cork's The Forgotten Children, a study of 115 children of alcoholics, ages 10-16. She reports that they felt responsible for parental drinking, felt unloved, were angry with the non-drinking parent for not protecting them, and feared the alcoholic parent would die. Their reactions were characterized by extreme mood swings and profound feelings of shame.

In 1973 Vernon Johnson used the term "co-alcoholism" to describe the damaging interpersonal dynamics within the alcoholic's family. Typically, the family's increasingly intense efforts to fix the alcoholic's behavior fail. In the process of focusing on the alcoholic member, other family members experience psychological damage from a sense of failure, fear, frustration, shame, inadequacy, guilt, resentment, self-pity, anger, a sense of worthlessness, and, a loss of being in touch with reality. Johnson's clinical work convinced him that successful treatment of the alcoholic also requires the treatment of the family members who have been thus affected (33-34).

The 1974 Booz-Allen and Hamilton report for the National Institute on Alcohol Abuse and Alcoholism followed children of alcoholics into their young adult years to

identify the long-term impact. They reported that children of alcoholics often experienced high levels of emotional neglect, family conflict, verbal abuse, parental absence, becoming a parental confidante, inconsistency, death or divorce of parents, sexual abuse, physical abuse, and health neglect. The report connected these childhood experiences to observed adult outcomes, including problems with opposite-sex relationships, leaving home at an early age, early marriage, over-achievement, lack of direction, depression, under-achievement, alcohol abuse, delinquency, suicidal ideation and attempts, teetotalism, low affect, confusion of sexual identity, addictions, unwed pregnancy, and, promiscuity. They found that many female children of alcoholics were attracted to males who resembled the father's patterns of being either possessive/dependent or brutal/aggressive. Nearly half of the female children of alcoholics married spouses with drinking problems.

Reviews of the research literature on the impact of living with an alcoholic have been offered by Ackerman and Gondolf; Adler and Raphael; Cotton; el-Guebaly and Offord; Heller, Sher and Benson; Jacob et al.; Orme and Rimmer; Poston et al.; Steinglass; Watters and Theimer; West and Prinz; Wilson and Orford; and, Woodside. Generally the reviews criticize the research as being flawed by methodological weaknesses, vague operational definitions, and the lack of controlled studies.

Attempts to use psychosocial testing instruments to distinguish between Adult Children of Alcoholics (ACOA) and others have been inconsistent. Reviews of research by Beardslee et al.; Cotton; Drake and Vaillant; Graybeal; Harrison; Sollars and Nardi report that research efforts that have failed to distinguish ACOA's by self-esteem, capacity for intimacy, role prediction, self-concept, locus of control, depression, Minnesota Multiphasic Personality Inventory, psychiatric disorders, problem with drinking, or, cognitive deficits. They also note research reporting significant differences between ACOA's and non-ACOA's in problem drinking and substance abuse, parentification and depression, incidents of abuse and psychological problems as adults, and, well-being.

In spite of the inconsistent findings and methodological weaknesses of the research in the reviews, Cotton; Harrison; Russell, Herders and Blume all note the clinical literature's consistent report that children of alcoholics have increased risk for becoming substance abusers, increased health problems throughout life, increased incidents of having been physically or sexually abused, and increased behavior problems in school (i.e. fatigue, poor impulse control, poor attendance, excessive concern for pleasing authorities, anxiety over contact between school and home). ACOA's are observed to experience increased psychosocial risks of experiencing low self-esteem, depression, anxiety,

hypervigilance, poor peer relationships, and, suicide attempts.

In his early research study, "Co-alcoholism: Recognizing a Treatable Disease" Whitfield observes that co-alcoholics adopt the same defenses used by their alcoholic family member, i.e. denial, repression, rationalization, projection, splitting, and grandiosity. The co-alcoholic family experiences chronic stress that results in "ill health or maladaptive, problematic, or dysfunctional behavior" (16), however these are secondary to the co-alcoholism. He observes that the effects of co-alcoholism go far beyond the immediate alcoholic family setting. "It [co-alcoholism] affects not only individuals, but families, communities, businesses and other institutions, and even states and countries" (17). He found co-alcoholism in the majority of people in helping professions, in law enforcement, in politics, and, in many employers (24). He also notes that the co-alcoholic terminology was transferred into drug treatment programs as "co-chemical dependence" and for convenience this was frequently shortened to "co-dependent" (17). Whitfield labels the behavior of the co-alcoholic as "psychopathology, illness and maladaptive behavior" (18) that is itself addictive and compulsive in its attempt to control the chemically dependent person." He calls the co-alcoholic's behavior a progressive and primary disease and cites that some co-alcoholic patients are "sicker than their

alcoholic." He observes that while the co-alcoholic's presenting problem may be a psychiatric illness or a debilitating physical illness, it is secondary to the primary treatment issue of co-alcoholism (18-19).

Whitfield identifies the untreated co-alcoholic's aggressive behaviors to include "repulsion, hatred, fantasies and dreams of the alcoholic's death, attempts to hurt the alcoholic, hatred of or refusal to have sex, attempts to avoid communication, verbal or physical abuse, and, temporary separation or divorce." Their passive behaviors include "hiding feelings, withdrawal, depression and extended crying, obsession with cleanliness or work, bargaining prayers, giving all love and attention to the children, phobias, anxiety disorders, and, developing symptoms to get the attention of the alcoholic or other." He also notes the strong tendency to find another dependent-prone relationship if the current one ends in divorce or death (20).

Family Systems Model of Codependency

Ackerman, Bowen, Creighton, Harrison, Kritsberg and Steinglass, working from family systems theory, all attribute the increased risks and variable impairments of adult children of alcoholics to the dysfunctional parenting experienced by the child, not to the drinking itself. In Same House Different Homes Ackerman observes:

> How the alcoholic fulfills his or her role as a parent affects children more than the drinking behaviors . . . If the drinking were leading to dysfunctional behaviors, no one would be upset

> with the drinking. It is the inability of the alcoholic parent to fulfill his or her various parental roles successfully that becomes detrimental to the children around the alcoholic (5).

Sharon Weigscheider applied the emerging understanding of family systems in her clinical work at the Johnson Institute and identified predictable role adjustments in alcoholic families. These role adaptations are dynamic and change as needed to meet the family's need for dysfunctional stability. In The Family Trap she identifies the characteristic adaptive roles as "chief enabler," "hero," "scapegoat," and "mascot." She later broadened her construct and offers an expanded etiology and definition that, "[A]nyone who lives in a family of denial, compulsive behavior, and emotional repression is vulnerable to co-dependency--even if there is no alcoholism or chemical dependency in the family. [Codependency is] a specific condition that is characterized by preoccupation and extreme dependence (emotionally, socially, and sometimes physically) on a person or object. Eventually this dependence on another person becomes a pathological condition that affects the co-dependent in all other relationships" (Another Chance 2). Weigscheider-Cruse offers eleven characteristics of codependent behavior based on her clinical observations (Ibid. xx). (Appendix B)

She outlines a four-stage model of codependency and addiction development. The first stage, "Dependent Bonding," is characterized by intense and one-sided bonding efforts. In the second stage, "Fear," separation and aban-

donment fears grow as control of the dependent relationship becomes more difficult. In the third stage of "Emotional Paralysis" spontaneity and joy are lost as the result of denying that other painful feelings exist. Finally, in stage four, "Behavioral Stuckness," behaviors become fixed, almost ritualistic patterns that assist in avoiding the pain of the reality in the relationship.

Subby and Friel conclude that "codependency is a condition which can emerge from any family system where certain unwritten, even unspoken, rules exist." Following these rules results in a "dysfunctional pattern of living and problem-solving . . . [and] make healthy growth and change very difficult" (31-32). These dysfunctional patterns include difficulty in identifying feelings, difficulty expressing feelings, difficulty forming and maintaining close relationships, perfectionism, rigid or stuck in attitudes and behavior, difficulty adjusting to change, feeling overly responsible for other people's behavior or feelings, constant need for other's approval in order to feel good about self, difficulty making decisions, general feelings of powerlessness over one's life, and, a basic sense of shame and low self-esteem over perceived failures in one's life. Stephanie Brown suggests that these family rules require the denial of the reality of the alcoholic's behavior and establishes a general cognitive distortion of reality in the other family members.

Beattie, Black, Larson, and Subby articulate for the general public the unspoken process rules that govern family life in alcoholic and dysfunctional families. Subby identifies these rules as:

- It's not okay to talk about real problems.
- Feelings should not be expressed openly.
- Communication is best if indirect, with one person acting as the messenger between two others (triangulation).
- Unrealistic expectations--be strong, good, right, prefect. Make us proud.
- Don't be selfish.
- Do as I say, not as I do.
- It's not okay to play or to be playful.
- Don't rock the boat (32, 34).

In It Will Never Happen To Me Black identified the "Don't Talk, Don't Feel, Don't Trust" rules that prohibit honest communication, prohibit healthy nurturing, and serve to keep change from happening. In Stage II Recovery: Life Beyond Addiction Larson identifies six stereotypical roles that are allowed in the dysfunctional and the alcoholic family systems, including Caretaker, People-Pleaser, Workaholic, Martyr, Perfectionist, and Tap Dancer. He labels these roles as survival and adaptive substitutes for intimate relationships that are not allowed or provided for in the dysfunctional or alcohol affected family. Larson calls these roles "self-defeating behaviors, greatly exaggerated and complicated by a pathological relationship to a chemically dependent person . . . that diminish our capacity to initiate or participate in loving relationships" (quoted in Cremak 5). Beattie's, Codependent No More focuses less on

explanation and more on hope for recovery. It was an immediate best seller, in part because it offered empowerment for change without long, expensive professional therapy. "Many recoveries from problems that involve a person's mind, emotions, and spirit are long and grueling. Not so, here. Except for normal human emotions we would be feeling anyway, and twinges of discomfort as we begin to behave differently, recovery from codependency is exciting. It is liberating . . . Recovery is not only fun, it is simple" (46-47).

Janet Woititz, whose dissertation research focused on the commonly observed low self-esteem issues in children of alcoholics, compiled the self-reported observations of her research sample of Adult Children of Alcoholics along with her own clinical observations and identified thirteen characteristics that were common to Adult Children of Alcoholics. (Appendix C) Her observations, first published as a pamphlet, became a grassroots best seller (with translations in five other languages). She suggests word of mouth created a demand by ACOA's who for the first time found confirmation that they were neither uniquely flawed nor alone with their struggles with adult life. She credits the book with generating an "international recognition that the impact of alcoholism on children is similar regardless of culture, race, national origin, religion, or economics. It is truly a pandemic. The language of suffering is universal" (xi).

She notes in the preface to the later edition that it

has become generally accepted that the same characteristics are common among adult children of dysfunctional families without alcohol issues. As examples she includes families where there were compulsive behaviors (gambling, drug abuse, or overeating), chronic illness, profound religious attitudes, or the child had been adopted into families or had lived in foster homes that were dysfunctional. Woititz's list of characteristics have been used as the basis of several efforts to develop instruments to measure the presence and degree of codependency (Harrison, Spann and Fischer, and Valentin).

Anne Wilson Schaef expands the concept of codependency beyond family systems theory to become a sociological paradigm. In When Society Becomes an Addict Schaef distinguishes between substance addictions (alcohol, drugs, nicotine, caffeine, food) and process addictions (accumulating money, gambling, sex, work, religion, worry, relationships) and labels all addiction as disease. Schaef finds the clearest indicator of addiction is one's sudden willingness "to deceive ourselves and others--to lie, deny, and cover up. An addiction is anything we are not willing to give up . . . is progressive, and it will lead to death unless we actively recover from it" (18).

Schaef identifies the codependent relationship as the basic form of relationship that is socially approved as "true love . . . when two people are incapable of function-

ing or even surviving without each other" (26). Codependents are not only products of dysfunctional family systems, they are products of the "addictive process" (39) that characterizes society holographically, in that the whole society reflects the characteristics of individual codependency. In Beyond Therapy, Beyond Science Schaef recalls confusion over her own and her clients' issues of codependency and recovery that remained as long as the focus was on being "cos" to someone's addiction (268). Only as she admitted having her own relationship addictions was she able to break free of a victim paradigm and be empowered to deal with the fundamental addiction process at work in her life. The addictive system is characterized by its "non-living" orientation that diminishes personal identity and power and encourages conformity. According to Schaef the addictive system is a spiritually bankrupt paradigm that defines morality in whatever way needed in order to support its addictive behavior. Recovery requires a paradigm shift to what she labels a Living Process System, a paradigm shift that is perhaps best facilitated by the Twelve Steps (Beyond 272).

Personality Disorder Model of Codependency

Currently, no commonly accepted specific diagnostic criteria for codependency is found in the psychiatric and mental health standard diagnostic reference, Diagnostic and Statistical Manual, III-R (DSM III-R). Without recognized and specific diagnostic criteria, codependency simply does

not exist for the mental health community. Timmon Cermak has argued that codependency should be recognized by the psychological and medical community as a disease--a personality disorder that is characterized as resulting in traits that are excessively rigid or intense and cause social or occupational impairment or significant subjective stress under the general heading of "mixed personality disorder" (10). Using the format of the DSM III-R, Cermak offers diagnostic criteria for the "Co-Dependent Personality Disorder." His model would require the presence of four criteria (i.e. continued attempts at controlling others in spite of adverse consequences; meeting other's needs while neglecting one's own needs; intimacy and separation anxiety and boundary distortions; enmeshed relationships with other addicted, co-dependent, personality disordered, or impulse disordered individuals), and, also require the observation of an additional three out of ten suggested traits commonly suggested by clinical observation. (Appendix D).

Wounded-Self Model of Codependency

In Adult Children: The Secrets of Dysfunctional Families, John and Linda Friel follow a family systems approach suggesting that the dynamics in dysfunctional families create the potential for wounding the individual's self-formation process sufficiently to create codependency along with other symptoms including addictions, stress disorders, and depression. However, they go on to offer a "General

Model of Adult Children and Co-dependency" to account for the intrapsychic dynamics of codependency, using the developmental work of Erik Erikson on identity formation. They propose the following definition of codependency:

> Co-dependency is a dysfunctional pattern of living which emerges from our family of origin as well as our culture, producing arrested identity development, and resulting in an over-reaction to things outside of us and an under-reaction to things inside of us. Left untreated, it can deteriorate into an addiction (157).

This model follows Erikson's eight stages of psychosocial crises. The model assumes that if the early stages are handled less than optimally, then adult identity formation is impaired to some degree. In dysfunctional families, the nurturing and emotional support are simply not there to assist children to optimally handle these earliest stages of identity formation (124).

The first four psychosocial stages (i.e. trust vs. mistrust, autonomy vs. shame and doubt, initiative vs. guilt, industry vs. inferiority) bring the individual to an identity crisis between ages 18 and 29 when their task is to become a separate adult identity. The four possible outcomes of this identity crisis include: Identity Achieved, Moratorium, Foreclosed, and Identity Confused (Diffused). Identity Achieved is the optimal outcome where enough personal struggle has happened in the major issues of life (i.e. vocation, religion, sexuality, political beliefs, lifestyle) that the individual has made clear commitments to

current choices. The internal congruency of feelings, actions and beliefs is more important to the individual than being compliant or pleasing to an outside authority. Moratorium is a continued crisis of actively searching for some direction in making the necessary commitments for separate identity.

The Foreclosed and Identity Confused outcomes are typical for Adult Children of Dysfunctional Families. In the Foreclosed outcome "we seem to have a clear set of commitments, but we never really went through a crisis period to get there" (130). The dysfunctional family system has a vested interest in preventing individuation and censures one for any effort to overcome their identity crisis and leave the family. They describe the emotional difficulty of such change: "Getting out of foreclosure is like standing on the edge of a cliff on a pitch-black night, and then jumping off without knowing whether the cliff is three feet high or 100 feet high" (131). The Identity Confused outcome is similar to Moratorium as a state of crisis, but the crisis "goes in circles without direction. We jump from one lover to the next, from one job or career to the next, from one set of beliefs to the next, and, from one lifestyle to the next. We are lost souls, wandering the earth looking for a sense of security in a way that we never got it" (131). They suggest that the individual in an Identity Confused outcome is externally referenced to find some

self-definition be it a role adopted early in life, an outside set of rigid rules and beliefs, or a charismatic leader. They note that any threat to that external source of self-definition serves as a threat to their very self and will not be tolerated.

Adult Children are portrayed as ill-prepared for Erikson's next stage of Intimacy versus Isolation. They distinguish intimacy from dependency. Intimacy is the "ability to be with someone without sacrificing our identity in the process. [but relationship] . . . with loss of self on a regular basis is not intimacy--it is dependency" (133). Successful working of the remaining psychosocial stages requires the Adult Child to enter a recovery program and deal with the wounds to the inner child. Without recovery, a high risk exists for addiction, compulsive behavior, stress, and depression. The Friels label these symptoms simply the above-surface manifestations of their "iceberg" model of codependency. Below the surface are the deeper realities of an inner child that has unsuccessfully negotiated their identity crisis and intimacy crisis. Recovery and treatment of the above-surface symptoms requires treatment of the underlying layer of codependency common to all and then reworking the basic psychosocial crises left from childhood.

While the Friels' model examines the family's influence on the making of a codependent, they also locate cultural

influences that damage self-identity formation, including authoritarian religion that mandates consideration of others' needs before one's own, schools that demand conformity of thinking and inhibit individuality, and, dependence on technology that alienates one from reality and increases the fear of being abandoned and helpless.

Lynn and Greenberg call attention in their research to the parallel of the general construct of codependency and Karen Horney's concept of morbid personality. Horney's morbid personality construct was a neurotic pattern that damaged what she called the Real Self, creating a self-diminishing condition that makes primary "the necessity of obtaining and pursuing affection, even at the expense of engaging in a dependent, exploitative relationship" (436). Mellody also notes this parallel in her research, calling Horney's morbid personality construct a "precursor" of the codependency construct (212).

Whitfield outlines a theory of codependency using the construct of the True Self/Child Within in his book Healing the Child Within. Whitfield freely synthesizes from self-psychologists, object relations theorists and transactional analysis theorists. He freely interchanges the terms Real Self, True Self, Child Within, Inner Child, Divine Child, and Higher Self as referring to the same description of "who we are when we feel most authentic, genuine, or spirited" (9). This Child Within is "spontaneous, expansive, loving,

giving, and communicating . . . is expressive, assertive, and creative. . . . And yet it is vulnerable, perhaps because it is so open and trusting" (10). The Inner Child contrasts with the False Self, Co-dependent Self, and, Public Self that is other-oriented. "It is inhibited, contracting, and fearful. It is our egocentric ego and superego, forever planning and plodding, continually selfish and withholding. It is envious, critical, idealized, blaming, shaming, and perfectionistic" (11).

Offering an alternative perspective, Whitfield compiles a hierarchical list of human needs that he suggests must be met for the Child Within's optimal functioning. In his view dysfunctional family circumstances serve to inhibit having these needs met, thereby minimizing the functioning of one's Child Within and giving dominance to one's False Self. Dysfunctional families include alcoholic or chemically dependent families, co-dependent families, families with chronic mental or physical illness, families that are extremely rigid, punitive, judgmental, non-loving, perfectionistic, or inadequate, families of child abuse, and families associated with post-traumatic stress disorder (26). Whitfield identifies shame as a common thread in the dysfunctional families' damage to the Child Within, calling the dysfunctional family "shame-based" (43). Whitfield notes that the Child Within can feel shame and express it in healthy ways, but the Co-dependent Self pretends to not have

it and "shame tends to accumulate and burden us more and more, until we become its victim" (45). Shame can be defended by the Co-dependent Self by disguising it as some other feeling and projecting that feeling onto others, yet it does not go away "unless I learn what it is, experience it and share it with safe and supportive others" (45). Dealing with core shame issues is critical for the recovery of the fully functioning Child Within.

Whitfield joins Cermak, Kritsberg, and Vaillant in linking codependency and Post-Traumatic Stress Disorder (PTSD) due to the cumulative effect of traumatic episodes in the family-of-origin. Whitfield observes in Spirituality in Recovery:

> PTSD is said to be more damaging and more difficult to treat if: (1) the trauma occurs over a prolonged e.g. longer than 6 months; and especially so if (2) the traumas are of human origin; and if (3) those around the affected person tend to deny the existence of the stressor or the stress. All three are present in an actively alcoholic family and in similar troubled families [underlines in original] (56).

Mendenhall's construct challenges the "family disease" concept of codependency as not honoring the seriousness of the effect on the individual's self. He labels codependency a "primary condition that results from the debilitating physiological stress produced by living in a committed relationship with an alcoholic or drug dependent person" (6). He suggests two common scenarios of self-wounding relationships with alcoholics that result in codependency.

His first example is the non-alcoholic spouse who marries an alcoholic and assumes the responsibility to resolve the spouse's drinking problem by reducing the alcoholic's pain, protecting the alcoholic from the consequences of drinking, and, caretaking. These efforts actually prevent learning feedback to the alcoholic and the non-alcoholic spouse is mystified when their efforts fail and so they try harder. The alcoholic's denial system and defenses strengthen leading to more failure and the non-alcoholic spouse begins to adopt the defenses of the alcoholic spouse against their own sense of failure, hopelessness, and humiliation.

His second example is the child in an alcoholic family who is not nurtured sufficiently and comes to assume early on that they are somehow responsible for their not being nurtured. At a very early age the child senses that they must grow up immediately and begin to take care of the alcoholic parent or the parent may die or go away. The child's self is wounded by internalizing the message that "it is not ok to be you." They defend themselves with denial and repression of emotional pain and fear, "[W]ithout denial or repression of pain, the child would be schizophrenic or homicidal" (8).

In either scenario the result is damage to the self schema that is experienced as "deep humiliation, intimidation, destruction of dignity, loss of power and torment"

(7). He suggests that codependents are not disturbed personalities but are persons reacting to high, chronic levels of stress to the point of impairment. Mendenhall continues the earlier, much criticized view that the codependent is "sicker than the alcoholic" by his emphasis on the seriousness of this high stress for the codependent, "[T]heir reserve depleted, [they will] never again [be] able to marshall the adaptive response to the degree they once could. Recovery for the codependent usually is less complete than the alcoholic because of this depletion" (13).

Criticism of the Codependency Construct

The construct of codependency is not without its critics who either disagree with a particular theory or with the construct as a whole. In The Truth About Addiction and Recovery Peele and Brodsky outline a psychosocial construct of addiction to critique the addiction-as-disease construct that is driven by the need for third-party reimbursement for the treatment industry and is rooted in a biological and medicalized model of addiction. Their stated purpose in writing Love and Addiction was to argue for a non-disease model of addiction in that, "[i]f love can be an addiction . . . then addiction is not what people think it is" (144). They locate the predisposition for addiction in the person's psychosocial experience of low sense of competency and a fear of failure. New opportunities are potential successes as much as they are potential failures. Anything that has

the potential to reduce anxiety and give psychological predictability can be used addictively (Ibid. 64).

Janice Haaken finds the various theories to be weakened by the lack of conformity to the research standards of psychoanalytic literature. She finds the literature to pathologize feminine identity issues related to caretaking and to overly simplify dependency issues. She also critiques Alcoholics Anonymous as a type of fundamentalism that offers a "mystical transformation of bad feelings into good feelings of peace and well-being . . by following a set of prescribed steps" (404), suggesting that Alcoholics Anonymous' model of transformation is better conceived as a reaction formation.

Kreston and Bepko offer a feminist critique of codependency that the construct pathologizes the way most families have socialized the female experience in society. Women have been socialized to tend to relationships and to put the needs of others before their own. In the process of being over-responsible for others, women have become out of touch with themselves and men have been crippled in expressing emotions and in relationships. Codependency is seen as a socially accepted way to redirect responsibility away from the alcoholic (whom they note are, for the large part, male) to women and children. "The codependency label, on a political level, becomes simply another tool in the oppression of women, fostering denial of male responsibility" (219). They

critique the assumption of much of the codependency literature that implies that health would be the paradox of "being perfectly fulfilled in relationship without ever focusing on the other person" (220). They suggest the construct of "over-functioning and under-functioning" in place of codependency. The task of therapeutic intervention is not to address an individual's sickness but to rebalance responsibility to self and others.

Tavris labels the codependency construct as, "an effort to solve the problem without changing the situation" (43). The "situation" in real life terms is that the kids are *hers* and the money is *his*; a formula for low self-esteem in women who must choose between financial success and family. Tavris objects to the attribution of blame on the spouse as codependent enabler to a helpless spouse and calls for interventions that confront both persons with making responsible choices. She also defines the "situation" that no one wants to change as society's comfort with women who feel inadequate, self-doubting, sick, and, diseased. Society is uncomfortable with women who are angry and confronting but is accepting of women who self-label as recovering addicts. "Women get much more sympathy and support when they define their problems in medical rather than political terms" (43).

Treadway critiques the disease model of codependency as a "no-fault construct" that only covers up blaming and is subject to abuse to avoid accepting responsibility. He

notes that many of his fellow family systems therapists are uncomfortable with the literal disease emphasis in much of the codependency literature. However, he observes that the popular literature uses the *family disease* construct of codependency primarily to offer the public a more easily understood metaphor as opposed to the more technical family systems terminology: complementarity, constructivism, enmeshment, circularity. He suggests that the discomfort of some therapists with the spiritual model of recovery is rooted in their own unresolved spiritual issues while others are threatened by confronting their own dysfunction as "caretakers with a career" (42). Treadway concludes that codependency is a product of the renegotiation of the traditional socialization of females as caretakers in that it "speaks to our efforts to re-examine the relationships between men and women . . . how does one share in a relationship without losing one's autonomy" (42). He notes the popularity of the twelve-step movement, the threat it represents to some therapists given their difficulty in acknowledging spirituality, and, focus on individuals at the expense of community. He sees the self-help movement's popularity as rooted in the breakdown of community, shared values and common purposes as well as an expression of the profound need of people for "a sense of community, empowerment, and spiritual renewal" (42).

Review of Selected Shame Literature

The review of selected shame literature will address shame both as a psychological construct and as a central theme in the Bible.

Selected Psychology of Shame Literature

Shame, as a psychological construct, has suffered from inattention compared to the attention given to the construct of guilt. The PsycLit CD-ROM database of psychological literature from January 1974 through September 1993 includes 717 references to "shame," with 415 of these dated after 1986. The same database included 3,348 references to "guilt" articles, with 1,836 of these dated after 1986.

Erikson, Nathanson, Schneider and Thrane each note in reviews of shame-related literature that little theoretical agreement exists as to the nature and origin of shame, its role in personality formation, or its role in psychological pathology. Much more agreement can be found in the literature about shame as a lived experience. The phenomenological studies of shame by Ablamowicz, Shapiro, and Vallelonga confirm shame's multidimensional nature experienced negatively as disesteem and positively as a facilitator of self-actualization. Shame is confusing in its relationship to the construct of guilt and in the numerous terms used in English to describe intensities of the same essential experience. Tomkins offers a phenomenological description of the shame experience typical of many other observers:

> If distress is the affect of suffering, shame is the affect of indignity, of transgression, of alienation. Though terror speaks to life and death and distress makes the world a veil of tears, yet shame strikes deepest into the heart of man. While terror and distress hurt, they are wounds from the outside which penetrate the smooth surface of the ego, but shame is felt as an inner torment, a sickness of the soul. It does not matter whether the humiliated one has been shamed by derisive laughter or whether he mocks himself, in either event he feels himself naked, defeated, alienated, lacking dignity and worth (118).

The modern study of shame as a factor in human psychology began with Burgess' 1839 essay on blushing in which he argued for a connection between natural experience and moral reasoning. A blush one's the face revealed to all observers whenever norms that were part of the "divinity that stirs within us" were violated; a blush was a spiritual phenomenon and the basis of a "sense of morality" (quoted in Schneider 2). Charles Darwin also began a study of human emotion in 1839, finally published in 1872 as The Expression of Emotion in Man and Animals, and supported the conclusion that blushing was a unique characteristic distinguishing humans from animals.

Although Freud, the father of modern psychotherapy, made reference to shame it played no major role in his understanding of human nature and its pathology. In his 1905 "Three Essays on the Theory of Human Sexuality" he suggested that shame was a drive inhibitor of what were natural and shameless experiences of the pleasure principle. Later in "Civilization and Its Discontents" he located

shame's origin in the evolution of humans into an upright posture that caused genital exposure (99). At nearly the same time his views seemed to shift from locating shame in genital exposure to shame as the need to hide genital deficiency, making shame a "feminine characteristic *par excellance*" (*Lectures* 164). For Freud, shame was more of an issue of false shame that served as an unconscious barrier of resistance to his therapeutic goal of uncovering more than the patient was willing to share. Broucek, Lynd, Miller, Schneider and others have offered various suggestions as to why Freud ignored his patients shame response as an appropriate response to his psychoanalytic invasion of their private space, however these are only speculations as Freud's psychoanalytic paradigm appears to not have allowed the question to surface to him. Goldberg has attempted a psychoanalytic recognition of shame by suggesting the "therapeutic use of intersubjective shame" that builds on the psychoanalyst becoming a "mentor of friendship" rather than another source for shame (199, 237).

Piers offered a psychoanalytic model of shame as the tension resulting from discrepancy between the ego's experience of reality and the goal of the ego-ideal. In contrast he conceived of guilt in terms of transgressions causing conflict between the ego and superego. Guilt anxiety presented to the ego the irrational and unconscious fear of guilt castration. Shame was a falling short or failure that

suggested the irrational and unconscious fear of abandonment (Piers and Singer 23-24). He developed a construct of shame and guilt cycles as a key to understanding certain psychopathologies and explored the role of shame in character formation, socialization, and therapeutic success. Based on Piers model and his own observations, Singer rejected the view that Western culture was primarily a guilt culture while most others were shame cultures, a view then accepted based on Mead's and Benedict's anthropological studies (96).

Erikson proposed a developmental understanding of the role of shame in his work on identity formation and life cycle. He proposed eight distinct yet interrelated developmental stages through which the individual passes during a normal life span. Healthy identity formation was related to the successful processing of the life crisis presented in each stage. In Erikson's model, the experience of the second stage would determine whether an individual's personality would be thereafter characterized by shame and self doubt or by the opposite, autonomy. The preceding stage determined the individual's basic sense of distrust or trust and the following stage determined their orientation to either guilt or to personal initiative. Kaufman observes that the negative result in each of Erikson's eight stages are elaborations of the experience of shame and that in each stage "each subsequent crisis involves, at least in part, a reworking of shame" (10).

Helen Lewis argues from a psychoanalytic position that shame is distinct from guilt, although both result from the same superego. She notes that shame feelings have more numerous variations (ie. humiliation, embarrassment, chagrin, disgrace, mortification, modesty, vanity, ridicule, dishonor, weakness, and narcissism) than guilt with guilt being a more objective experience. She links shame to feelings of depression and guilt to obsessive thinking. Shame is a universally experienced emotion that has a distinct physical manifestation: blushing, a wish to cover the face, and a desire to sink into the ground.

Helen Lynd, a critic of psychoanalysis and its theory, identifies with Erikson's developmental work and wrote that, "[I]dentity cannot be reached along the guilt axis alone, that more is needed than discarding specific wrong acts and substituting specific right acts for them" (209). She identifies shame as a key to healthy identity formation and to discovering unrecognized parts of both one's self and of society (183). She also located multidimensional barriers to such a healing process in the uncritical adoption of socially approved rules (182-185); exalting the inner life over the importance of social interaction as in existentialism (193-194); and, the use of tradition without responsible adaptation of interpretation (195). These barriers reinforce shame and result in personal and social dehumanization, alienation, and <u>anomie</u>, a feeling that "nothing makes

a difference and eventually that nothing is real" (192).

She observed that the experience of shame may include any combination of, or all of, the following feelings:

1. Exposure, particularly unexpected exposure to others, but also to oneself. She noted that "deep shame" is experienced in the discovery of deception of others about oneself. Shame was a sudden and unexpected invasion of the self, where as guilt involved "foresight, choices, and awareness" (27-34).

2. Incongruity or inappropriate actions in a particular setting that are a contrast to one's self-image may result in shame as a loss of identity, being confounded, or confused (34-43).

3. A threat to trust where awareness that hopes or particular expectations will not be realized leads to a sense of inadequacy or to questioning what has been accepted as reality--a disillusionment. She noted that the experience of the physical world as unpredictable or incoherent can lead to doubt in self, particularly in children (43-49).

4. Involvement of the whole self in shame. Guilt is wrong action that occurs outside the self and is redeemable. Shame "cannot be modified by addition, or wiped away by subtraction, or exorcised

by expiation. It was not an isolated act that can be detached from the self. . . . The thing that has been exposed is what I am" (50). She added that remediation of shame required a "transformation of the self . . . in Plato's words, a turning of the whole soul toward the light" (51).

5. Shame as the confronting of tragedy can be experienced by the self for the actions of others that are merely observed. Such experiences can lead to questioning the validity and adequacy of society as well as the meaning of truth and life; suddenly life seems tragic and meaningless. Shame leads to painful questions about personal significance.

6. Difficulty in communicating shame. Shame is experienced as overwhelming to the self, a sense of depressed inadequacy that is confounding, confusing, anxiety producing, and isolating. To be open risks additional shame, however communicating the shame experience to others and facing it fully leads to transformation of the self (63-71, 249).

Lynd theorizes that shame is dynamic, not static, and falls along a strong-weak continuum where the self experiences varying degrees of being small, inadequate, or lacking. She identifies a shame-proneness in some individuals that makes positive self-regard and self-respect incredible

if not impossible (253). She argues that an individual's shame-proneness impacts their identity formation, a life-long dialectic of relatedness to self and others, in that shame restricts the openness required to develop healthy relationships. The healthy relationships that facilitate identity formation are characterized as loving experiences where one's shame can be exposed without shame; transforming shame by its being shared and understood. "Love increasingly transcends power, anxiety, and shame. A person who cannot love, cannot reveal himself" (241).

Schneider explores what he labels the "two faces of shame" suggesting that shame is experienced separately as discretion and disgrace. He notes that most Indo-European languages have multiple words for shame that distinguish a sense of shame as discretion before an action (with shamelessness as moral deficiency) from the disgrace of having done some action. He located two language roots from which these faces of shame result: *(s)qewa and *(s)kam. Both roots mean "to cover" but one suggests the covering of sexual organs and the other the covering of the self (30-31). He notes the dynamic interplay in many languages between the "exposure" and "covering" themes related to shame.

Schneider also links shame and the experience of awe or reverence before the sacred. "A sense of shame is a lovely sign in a man. Whoever has a sense of shame will not sin so

quickly; but whoever shows no sense of sin in his visage, his father surely never stood on Mount Sinai" (109). He notes the predominance of shame terminology in both the Old and New Testaments, but suggests that the link between shame and awe is not obvious to contemporary Western thought that objectifies the world as a utilitarian and a technological thing rather than as a mystery (111). He locates the link missing between the experience of the sacred in the Old Testament and modern humanity's experience of the sacred in the term "fear." The common Old Testament phrase "the fear of the Lord" describes an attitude of reverence; a reverence or awe that was a "type of fear whose object enjoys respect and love at the same time" (112). He also notes an absence of the Old Testament's emphasis on a "sense of shame" in the New Testament but finds that the absence does not negate the importance of shame before the sacred as a condition to experience the holy. He offers a critique of Western Christian theological tradition in its dismissal of shame and concentration on guilt which leads to "conceiving of sin in terms of moralism and specific wrongdoing, rather than as a failure of trust and a break in relationship" (113). He argues that the absence of an emphasis on shame in the New Testament adds an "uncovering" theme to the "covering" (ie. covering in the Garden first with leaves and then with animal skins supplied by God and the literal meaning of atonement) theme of the Old Testament.

> The religious encounter is not only one of reticence before that which one venerates; it also involves the revelation of what is hidden. Religion may be understood as the dialectic of covering and uncovering of the sacred in time and space. . . . The freedom and intimacy of the New Testament presuppose the restraint and respect of the Old Testament. The invitation to address God as 'Abba' is issued to those who dared not to utter His Name (116).

Wurmser distinguishes three states of shame experience: shame anxiety, being ashamed, and, having a sense of shame. Shame anxiety is a painful awareness that something has happened that is potentially shameful in spite of all efforts to avoid the shame. Shame is a sudden experience of exposure to the risk of being held in contempt and to be rejected. Being ashamed is a sense of a diminished self as the result of something that has already happened; a sense of disgrace that threatens identity. By sense of shame, Wurmser means a reaction formation that is adaptive as a restraint on behavior. While a sense of shame as restraint is an adaptive process that can be used in positive ways by the individual, Wurmser finds it can be internalized as a reaction to an exaggerated ego ideal, becoming the root of pathological narcissism.

Much of the more recent shame literature has been built on the work of Silvan Tomkins who develops a construct of nine universal innate affects as the basis of human emotion and motivation in contrast to Freudian drive theory. In his theoretical construct, Tomkins' attempts to explain human emotion through the biology of brain function and brain

chemistry. For Tomkins, triggering an "affect" means that a definable stimulus has activated a mechanism that in turn has started a known pattern of biological events that are genetically transmitted.

Different affects are experienced as the result of variations in the patterns of intensity and duration in brain neurotransmitter firings. Two affects are positive: interest-excitement and enjoyment-joy. Three are negative affects: fear-terror, anger-rage, distress-anguish. One is a neutral resetting affect: surprise. Two are drive auxiliary affects: disgust as a limit to the hunger drive by taste and dismell as a limit to the hunger and breathing drive by smell. Shame is also an affect auxiliary, but auxiliary to the two positive affects not to drives.

Shame affect, an experience of self-consciousness, is triggered as an incomplete reduction in the positive affects of interest-excitement or enjoyment-joy that are characterized by a lack of self-consciousness. Shame results when a barrier to the continuation of the positive affects is experienced that reduces interest or enjoyment but does not destroy the possibility of their return. Like all affects, shame has innate universal characteristic facial expressions and physiological display that serve to communicate its presence: blushing, lowering the head, and the averting of eye contact. Shame is displayed as a loss of face (133). Attempts to defend against shame display include: a "frozen

face" since knowing one is blushing is also shaming; a "head back" posture to offset the lowered eyes; and a "look of contempt" that recasts the shamer into the shamed (145-146). Tomkins calls shame an "inner wound" that directly affects both identity formation and relationship formation which in turn compounds into feelings of helplessness and feeling flawed as a person (118).

In Tomkins view, guilt is not an innate affect but shame about moral transgression. Guilt, as moral shame, can be co-assembled with other affects to present different experienced feelings including: moral distress where grief feelings are prominent; moral disgust as self-contempt; moral anger in the form of self-blame or self-accusation; or, the moral fear of exposure.

Following Tomkins' affect theory, Kaufman identifies the interpersonal nature of shame, suggesting that shame is activated by the "breaking of the interpersonal bridge" (32). Shame is always at risk in relationship. The bonding of parent to child, between siblings, and of self to friends all provide interpersonal bridges built on increased positive affects, the reduction of negative affects, empathetic touching, facial communication, reciprocal trust, shared interest, constancy and predictability. A break in this interpersonal bridge results in shame. Reparation of breaks, and thereby shame, can come only by the open, honest acknowledgement of one's role in the breaking process--the

very process that shame attempts to avoid.

Kaufman follows Tomkins in building a mechanism for the internalization of shame as a characterization of the self as "shame-bound" (58). By means of the imagery of experience that is imprinted with shame affect, the self internalizes shaming experiences as scenes in the memory. Shame-scenes are organized around four distinct clusters of the self as "affect shame," "drive shame," "interpersonal need shame," and "purpose shame" (90). Each shame scene has three inter-related components:

1. "affect-belief"--a cognitive label imprinted with the scene that is internalized and serves to recall past shame scenes when heard as an externally applied label or as an internal voice (ie. 'stupid');

2. "image of interactional patterns"--the image of the interaction with others in shaming experiences is stored to become a recognized and repeatable pattern becoming a self attribution (ie. blaming by others becomes self-blaming); and,

3. "internalized other"--an identification image that Kaufman finds originating with one or both parents that becomes the auditory component of internalized shame and can become confused with one's own inner voice (84-85).

> Sufficient and necessary repetitions of the particular affect-shame, drive-shame, or interpersonal need-shame create the internalized shame linkage or bind. When the expression of any affect, drive, or need becomes associated with shame, then later experiences of these affects, drives, or

> needs spontaneously activate shame by triggering the entire scene. Shame need no longer be directly activated. The particular affect, drive, or interpersonal need itself becomes bound by shame, its expression thereby constricted (86).

Kaufman attempts to re-conceptualize psychopathology from the perspective of shame by using Tomkins' theory that shame scenes can become psychologically magnified into internalized scripts that are accepted as reality. Such scripts can serve either as the basis of personality integration or personality pathology (90f).

The link between shame and psychopathology has been suggested by others. Morrison has written extensively using a blend of Piers' shame construct and the self-psychology of Kohut to link shame and narcissism. Broucek uses a different construct but also links shame and narcissism as an internalized condition of the self: "Shame is the instigating force in the creation of the idealized self and the construction of an idealized self always implies the coexistence of a devalued shame-ridden self which is in dynamic interaction with the idealized self" (59). Wurmser, Lewis, Kinston, and Nathanson suggest similar links between shame and narcissism.

Harper and Hooper follow Tomkins' affect theory, as well as Kaufman's construct of the internalization of shame, to expand an individual's shame-proneness to explain that an entire family can become shame-bound. They link humiliation, shame experienced as worthlessness, to the unmet

psychological need of parental acceptance. They identify five additional basic needs (intimacy, productivity, sense and order, uniqueness, and having choices) and suggest the interpersonal issues faced by the person whose family system fails to meet these needs (insufficiency, rejection, abandonment, emptiness, and loss). It should be noted that all of the responses are characteristics of shame (42). They label family systems that fail to meet these basic needs as "dysfunctional" and attempt to develop a construct of therapeutic intervention for shame-bound individuals and families.

Another body of recent shame literature comes from the addiction and codependency recovery community including Bradshaw, Fossom and Mason, and Potter-Efron. They generally distinguish between shame as a healthy experience and the unhealthy experience of either too little shame (shamelessness) or too much shame (ie. becoming shame bound or having toxic shame). They follow others in the recovery literature in naming shame as a core issue in addictions in that the addiction is a self-defeating attempt to avoid facing shame that is internalized as self image, however offer little consistent theoretical basis to explain shame's internalization. In "Measuring Shame: The Internalized Shame Scale" Cook calls attention to clinical observations from the addiction treatment field that assume shame has continuous dimensions including frequency and intensity. He documents

his early efforts to develop an instrument to measure internalized shame.

In "Shame, Attachment and Psychopathology" Cook combines Tomkin's affect theory of shame, Nathanson's and Kaufman's theories on the internalization of shame scripts, Bowlby's attachment theory, and Epstein's cognitive-experiential self theory. His purpose is to suggest how shame can be internalized as "the governing source of our self identity" (7) leading to becoming a "shame-based personality" (8, 24). Cook links Epstein's model of self schema development with Bowlby's attachment theory in that both locate the potential for the maladjustment in the "emotional stress in interaction with the child's caregiver(s)" (4). He reports on a review of infant studies in which Tronick identifies negative affective interactions (labeled proto-shame affect by Cook) of infants and caregivers and concludes that "with reiteration and accumulation of failure and nonreparation, the infant develops a representation of himself or herself as ineffective and of the caretaker as unreliable" (quoted in "Attachment" 15). Cook finds in Tronick's observations a basis for the "intergenerational transmission of depression or other possible psychological patterns that have roots in the link between triggered shame affect and associated experiences with caregivers" (15). Cook calls for psychological researchers and theoreticians to recognize the role of shame affect in identity formation and psychopathology

and suggests that his Internalized Shame Scale offers a means to quantify internalized shame (38-39).

The relationship of shame and spirituality has not been widely researched. Pruyser reviews the theological literature on theories of atonement identifying the primary theories as: "Ransom Theory," "Satisfaction Theory," and, "Moral Influence Theory." He reports finding symbolic values imbedded in each theory that he correlates with the respective psychological constructs: "Anxiety," "Guilt," and, "Shame." He links the Moral Influence Theory to shame through the writings of Paul, Gregory of Nazianzous, Abilard, and, Grotius and finds it rooted "in Athanasius' conviction that the consequence, if not the purpose, of the atonement was to restore the defaced imago dei in humans so that moral and social betterment might ensue" (20). He identifies key symbolism in the Moral Influence Theory's impetus to spirituality in that "it ranks God's goodness as his highest attribute, making his mercy necessary, and his justice optional . . . [and] sets up Christ as an example to be followed rather than as a expiatory sacrifice, though elements of the latter are not missing" (20). He warns that each of the theories may include symbolic representations that either facilitate or debilitate the believer's mental health and calls for additional research.

In No Condemnation Bruce Narramore distinguishes "guilt feelings" from "Godly sorrow" in that guilt feelings, i.e. false guilt, lead to autonomous self-punishing efforts to make reparations that result in legalistic conformity, rebellion, depression, maladjustment, and hinder spiritual well-being. In contrast, "Godly sorrow," i.e. real guilt, is an emotionally and spiritually healthy response leading to a healthy dependence on God, sincere regret, reparations based on respect for others and for self, and constructive psychosocial and spiritual changes. In "Psychoanalytic Contributions to the Christian View of Guilt" Narramore cites the acceptance of a distinction between real guilt and false guilt as "the single most important psychoanalytic contribution to the Christian view of guilt" (120). This distinction, made in recent Christian psychological literature by Tournier, Collins, Hyder, C. M. Narramore, and Pattison, offers a way to hold on to real guilt for which divine forgiveness is needed and to offer hope to those who experience false guilt. The church's failure to make this distinction leaves the person experiencing false guilt "engaging in repeated cycles of confession and self-condemnation" (Ibid.). Narramore stays within the psychoanalytic paradigm and merges shame and guilt with "shame as one constituent element of guilt emotion. . . . [that is] comprised of internalized fears of punishment, rejection, and loss of self-esteem" (120). He suggests that this submerging of

shame under guilt suggests the application of specific biblical doctrines to counter each of the internalized shame-based fears. Bassett et al. in "Comparing Psychological Guilt and Godly Sorrow: Do Christians Recognize the Difference?" report their empirical research that supports Narramore's distinction and that "mature Christians" were generally better able to make the distinction. However, the distinction is not without confusion in that the psychological language of self-esteem and the theological language of pride are ideologically different and biasing to their research results. "Our impression is that many Christians find positive self-esteem to be frighteningly close to pride" (254).

Binau, in contrast to Narramore and others, calls for the theological and therapeutic distinction of shame and guilt. He traces the psychological concepts of shame and outlines biblical uses of shame to suggest a "relational anthropology" rooted in the covenant relationship of God and humans. He finds common theological ground to link Law and shame in Luther's "second use" of law, i.e. to expose one's alienation from God resulting from sin, and Bonhoffer's naming of that experience of exposure as "shame" resulting from broken covenant relationship (140). He offers a shame-informed view of baptismal theology, grounded in Luther's theology, that emphasizes the sacrament of baptism as the restoration of covenant relationship and the

basis for being unashamed before God. He proposes this view as an alternative to traditional baptismal theology that is limited by a "guilt paradigm of the human predicament" (141).

Watson, Morris and Hood report research that suggests the relationship between shame, spirituality and self-functioning in "Sin and Self Functioning, Part I: Grace, Guilt, and Self-Consciousness." Referring to Narramore's distinction of guilt and Godly sorrow, they hypothesize that "[i]f religious understandings of sin promote a prosocial sensitivity to others, then a direct relationship with this form of self-consciousness would be expected" (258). Self-consciousness was operationalized as Public Self-Consciousness, "sensitivity to how one appears to others," and Private Self-Consciousness, "awareness of one's own thoughts and feelings" (258). Healthy spiritual functioning is operationalized as Intrinsic Religious Orientation. The results support their hypothesis, showing positive correlations between Intrinsic Religious Orientation, Internal State of Awareness [a subscale of Private Self-Consciousness], and negative correlations with measures of depression and maladjustment.

In The Depleted Self: Sin in a Narcissistic Age Donald Capps reviews clinical literature that links shame and narcissism, calling into question the pastoral counseling movement's paradigm that uncritical accepts anxiety as being

rooted only in "the ontological condition of guilt" (7). Noting Christopher Lasch's arguments that a new self has emerged out of the experience of the twentieth century that is narcissistic in nature, Capps suggests that theologians have tended to view shame as violations of social mores and customs, but "not as an issue of vital importance to our understanding of Christian faith and life" (84-85). He identifies several sources for the theological failure to treat shame seriously including: the social bias of Western culture to see itself as a more advanced guilt culture and Asian shame cultures as less advanced; the male domination of theological studies as some studies show men are more socialized to experience guilt and women to experience shame; and, theologies built on a guilt paradigm. He notes the contemporary societal response to the church's guilt-based sin language is one of irrelevance and devaluation of the church's message. His review of clinical literature suggests that the contemporary cultural narcissist does not experience guilt to any significant degree and that "shame has replaced guilt as the experience that causes individuals to feel bad about themselves, to feel that something is seriously wrong with them" (39). He builds an argument for the formulation of a shame theology that re-conceptualizes both sin and salvation from a shame paradigm rather than exclusively from a guilt paradigm.

Shame Themes in Selected Biblical Literature

The extent of shame terminology in biblical material is ubiquitous, yet, may be the most overlooked aspect of theological and biblical studies. Lynd and Schneider note that shame words (ie: shame, shamed, shamefacedness, shamefully, shamelessly, ashamed, disgrace) far outnumber guilt words (ie: guilt, guilty, guiltiness, guiltless) in the Bible. Simple English word counts show the following comparisons: the KJV uses shame words 232 times and only uses thirty-three guilt words (Young); the NIV uses shame words 304 times and only uses 196 guilt words (Goodrick). Similar relative differences are found in the frequency of Hebrew and Greek shame words to Hebrew and Greek guilt words.

The suggestion that shame has been overlooked by theologians and Bible scholars is reinforced by a survey of major theological and biblical journals. A search of religious periodicals using the ATLA Religion Database located only sixty-four shame related references (the earliest printed in 1928) as compared to 292 guilt related references. A similar search of the Religion and Theological Abstracts on CD-ROM located only 103 shame related references but 574 guilt references.

Word frequencies of English, Hebrew and Greek terms does not permit conclusions as to their relative importance, only context can determine a term's meaning and significance. The following is not a critical word study of Hebrew

or Greek terms, but an effort to explore general observations about the shame themes in Scripture.

Old Testament Shame Themes. The Old Testament story of humanity begins the story of the role of shame in human relationship to God and to one another. The Garden of Eden is characterized as being well watered and well pleasing with humans assigned to cultivate it with unrestrained access to everything in the Garden except the tree of the knowledge of good and evil. Adam and Eve are characterized as being "both naked and were not ashamed" (Genesis 2:8-25; Biblical references are NASB unless otherwise noted.) before their disobedience. Although the Hebrew term for "ashamed" does not appear in the story after their disobedience it is clearly implied by their sudden self-consciousness, their desire to hide from each other, and fear of exposure to God after their disobedience (Genesis 3:7-11). Self-consciousness is portrayed as being born in the Garden's sin-scene and innocence (i.e. the absence of self-consciousness) died. While arguments and interpretations about the Garden and humanity's sin have abounded for centuries much of the focus has been on the sinlessness of human character before their disobedience or on the perfection of the Garden. However, a simple reading of the text allows placing the primary focus on the change in humans from a state of unbroken, unself-conscious unity to a state of brokenness and objectified self-consciousness. The Garden is portrayed as the begin-

ning of humanity's desire to hide from each other and from God.

The primary Hebrew terms translated with English shame words are bosh and kalam. Cognates and other less frequently used words include: bashnah, bosheth, buz, yabash, chapher, cherpah, ervah, galah, kelimmah, kelimmuth, nabel, shimtsah, qalom, and qiqalom (De Vries; Dozeman; Oswalt; Young).

The Hebrew word group kalam is usually translated, "To be ashamed, confounded, reproached, hurt, be put to shame, be put to confusion, blush" (Oswalt 443). Oswalt found it used on thirty occasions (out of its forty uses) as a parallel term with bosh, suggesting that the terms have little distinction. However, he identified kalam as having a more general sense of disgrace and public humiliation whereas in bosh the emphasis is on a failed sense of trust (Ibid.).

The primary Hebrew word group translated as shame is bosh and its derivatives. Oswalt identifies 155 uses (with derivatives) in the Old Testament where the primary meaning is, "To fall into disgrace, normally through failure, either of self or an object of trust" (97). Few of these references are found outside the Prophets or Psalms. Vine adds the English word "worthlessness" to his list of possible translations for bosh (227).

Oswalt suggests that the bosh word group conveys less of a subjective inner experience of being ashamed and more

of an objective physical state of public disgrace (97). In the same way, De Vries divides the biblical references into subjective shame as "guilt for sin" and objective shame as "disgrace which a sinner brings upon himself and those associated with him" (306). However, this division of shame appears to be a reductionism that is neither justified by the phenomenology of shame nor required by the biblical material. Seebass examines terms used in parallel with bosh including: chathath--to be dismayed; pachadh--to dread; sughachor--to turn away from; chavar--to grow pale; nadham-mah--to be silenced; shadhadh--to be devastated; abhadh--to punish; and, kalah--to be destroyed (50). These parallel uses confirm the phenomenology of shame conveyed by bosh is both complex and dynamic.

Public humiliation is an Old Testament shame theme. For example, Mariam was punished publicly with leprosy for her sinful speech in opposition to Moses' leadership. Moses appeals for God's immediate healing. But God is reported as pointing out that the, mild by comparison, rebuke of her father in the form of spitting in her face would require seven days of public humiliation "outside the camp" and that after seven days of physical public shame and separation she would be healed (Numbers 12:14). In another example, Jonathan experienced public humiliation at his father's public attempt to kill David (I Samuel 20:33-34). Saul's angry outburst of shame-rage at David followed his expression of

shame over Jonathan's public support of David over his own father, an action Saul characterized as shaming to Jonathan's mother who would be at David's mercy should Saul die (I Samuel 25:30). A shame spiral began that could not be stopped.

The Old Testament portrayal of David offers additional examples of shame as public humiliation. For example, David suffered public humiliation by Nabal's rejection of David's request to be compensated for the protection provided to Nabal and his servants. This story's importance is suggested by the inclusion of significant details, e.g. Nabal was both wealthy as well as "harsh and evil in his dealings", but his wife, Abigal, was "intelligent and beautiful" (I Samuel 25:3). In the face of Nabal's shameless response to his protector David, Abigail experienced vicarious humiliation over her husband's actions. She risked personal shame to intercede with David without her husband's knowledge and took on Nabal's shame. To save her husband's face she presented offerings to repair David's honor and asked him to forgive the "transgression of your maidservant" and to withhold the shedding of blood (I Samuel 25: 26-35). She reminded David that Nabal's name literally meant "fool" and he had lived up to his name (I Samuel 25:25).

Perhaps the classic Old Testament example of public humiliation for personal iniquity is Nathan's confrontation of David for his shameless adultery and murder of Uriah in

II Samuel 12. The consequences for the sin announced by Nathan have a shame theme of personal powerlessness in that David would be confronted by an unavoidable violent future (12:10), his inevitable downfall would come from within his own family and his wives would be given to "your companion, and he shall lie with them in broad daylight" (12:11), and his child born of the adultery would die (12:14). David acknowledged that his sin was against God who had established a special relationship with him (12:7-8). His sin dishonored God by giving "occasion to the enemies of the Lord to blaspheme" (12:14; see also Romans 2:24). Psalm 51 is linked by its introduction of David's confrontation by Nathan. While a request to be delivered from "bloodguiltiness" (51:14) is included, it can be argued that the shame theme of restoring lost face and thereby David's previous special relationship to God is predominant (i.e. cleansing of whole self, removal of iniquity that makes restoration of face impossible, the return of a spirit of being unashamed in the presence of God, and bold praise to offset the blaspheming of others).

The paradoxical nature of shame is also found as a shame theme. David is charged with foolish shamelessness by his wife Michal who was humiliated ("she despised him in her heart") when she and her maid servants saw him celebrating and "dancing before the Lord" in a way that exposed his nakedness. David defended this exuberance as part of his

overwhelming experience of the Sacred in worship. The pericope concludes with the shame reference that Michal remained barren to her death (II Samuel 6:20-23).

The paradox of shame is also found in David's experience of grief that resulted in the humiliation of his troops who returned from battle having defeated Absalom and his forces Instead of being greeted as loyal heroes, they find David weeping over the loss of his son Absalom. Their shame is only repaired when David is convinced by Joab to go out to his servants and speak to them (II Samuel 19:3, 5). The roots of this double-binding shame scene may be in the earlier rape of Tamar by her step-brother Amnon, David's first born son. Unexplainably, David did not address the rape at the time although he was "very angry." David's avoidance of the crisis solved little except to delay the family crisis until Absalom finally took it into his own hand to kill Amnon and redress the shame to Tamar (II Samuel 13:10-14. 20-32).

Shame in the Old Testament is also shown as an appropriate experience whenever public humiliation is absent but is expected. Jeremiah charges that Israel was not ashamed of their abomination and "did not know how to blush" (3:3; 6:15; 8:12). Ezekiel notes that even the Philistines were embarrassed at Israel's lewd conduct (16:27) and Zephaniah condemns the shamelessness of those who are unjust (3:5). Ezra is overcome by shame at the prevalence of forbidden

intermarriage by the exiles with their pagan neighbors. He exclaims his embarrassment to face God "for our iniquities have risen above our heads and our guilt has grown even to the heavens" (9:5-6).

Paradoxically, God's grace and undeserved forgiveness also results in a sense of shame that will serve to guide Israel's faithfulness in the future. Ezekiel suggests that Israel's sins made the sins of Sodom and Samaria more respectable, heaping more shame and disgrace on Israel. Yet, he foresees restoration, "in order that you may bear your humiliation and feel ashamed for all you have done when you became a consolation to them" (16:54). The renewed covenant, restored because of Yahweh's namesake and not because of Israel's actions (36:22-25), will be a reminder of Israel's past shameful actions and a deterrent to future shameful choices (16:61, 63), will be a key to knowledge of faithful worship (43:10-11), will be a cleansing from filthiness (36:25), and, will be acceptance before God (43:27).

Bosh is most frequently used as shame resulting from disappointed trust and lost hope (Dozeman, Oswalt). The very nature of placing trust and hope in something, whether in oneself, idols, foreign powers, or in Yahweh, exposes one to risk and shame if that object of trust and hope disappoints. Shame as disappointment and lost hope is expressed in Psalm 44 for Israel's defeat by God's absence. God's absence from their presence led to defeat and made them a

"laughingstock" among nations (44:9, 15). Jeremiah uses this same sense of disillusionment where God's absence resulted in the absence of blessings, having no water to drink nor rain to supply crops. Israel's prosperity was tied to their hope in God's blessings, a hope that by its very nature exposed them to shame when God withheld his blessings (14:3-4, 21).

Shame was the consequence of placing trust in idols or in foreign powers to save Israel from invasion when Yahweh had forbidden the use of any idols and was directing the actions of foreign nations against Israel Himself (Isaiah 30:3-5; 42:7; 44:9-11; 45:16-17; Jeremiah 2:36; 11:13; 13:26; 46:12). Israel's idolatry was unfaithfulness in the form of distrust in Yahwah. Jeremiah compares the shame of being found with idols to the shame a thief experiences being discovered (2:26) and declares this to be "uncleanness" (13:26). The prophets also called to Israel's attention that the foreign powers carrying out the captivity would also come to shame (Isaiah 41:11; 47:3; Jeremiah 48:13, 19; 50:11; 51:51).

The prophets reminded Israel that their only hope was God. And then, only their continued faithfulness would assure the realization of their hope. Jeremiah has God declaring: "Cursed is the man who trusts in mankind and who makes flesh his strength, and whose heart turns away from the Lord. . . . Blessed is the man who trusts in the Lord

and whose trust is the Lord. . . . O Lord, the hope of Israel, all who forsake thee will be put to shame" (17:5, 7, 13a). Isaiah also hears Yahweh declare His gracious restoration for Israel and the warning that forsaking Yahweh, forgetting the holy mountain, courting with Destiny and Fortune, not hearing Yahweh's call, and doing evil in His sight will result in shame (65:11-14).

The Psalms contain numerous shame terms and shame themes even where the term does not appear The very nature of the Psalms as expressions of the deepest human emotions of hope, longing, trust, distrust, fear, etc. to God make them likely to have significant shame themes. Anxiety about guilt is found in the Psalms, but anxiety about loss of face, helplessness, powerlessness, as well as the Psalmist's trust and hope in God dominate. Sounding vindictive, shame and disgrace are requested as an end for the Psalmist's enemies. Seebass found this request (used sixteen times) to be less a request for personal revenge than to be simply the logical conclusion of the hope and faith one has put in God and God's response to those who are unfaithful (59). Psalm 83 has a similar use, however, there the enemies are not personal enemies, but the enemies of God who have made a covenant against Him. They are people who deserve to be "ashamed and dismayed forever," to be "humiliated" and to "perish" (83:17).

In Proverbs shame is contrasted with honor, humility,

prudence, righteousness, and wisdom. Shame is parallel to adultery, choosing shameless companions, foolish actions, pride, speaking too quickly, undisciplined living, and wickedness (3:35; 6:33; 10:5; 11:2; 12:16; 13:5; 13:18; 14:34-35; 18:13; 25:8, 10). Shame is portrayed as being experienced based on another person's action. For example, the shameful actions of a wife can affect a husband and put "rottenness in his bones" (12:4); the shame of an assault on one's mother and father (19:26); or, the shame when a child rules a household (29:15). A servant who acts wisely may rule over a son whose actions have been shameful, further shaming the son (17:2).

Another key to understanding shame in the Old Testament is found in those references to the positive quality of "not being ashamed" (i.e. not as shamelessness but as unashamed confidence, paradoxically requiring a healthy sense of shame for moral restraint). Examples of the positive quality of "not being ashamed" are found in Psalms 25, 31, 34, 37, and 119. These Psalms convey the absence of shame as having confidence before God and the community of faith that makes possible the lifting up one's soul before God (21:1; 34:5); desiring to know God's ways (25:4, 119:19, 26f.); and, having God's face to shine on one's face (31:6). Such confidence is the antithesis of shame experiences that result in a loss of face or a desire to hide.

This unashamed confidence is characterized by an inti-

macy and honesty with God. What might otherwise be held in secret before others is open for God to see, including the Psalmist's potentially shameful sense of loneliness, affliction, trouble, distress, sin, hatred of others, grief, sorrow, failed strength, iniquity, reproach to neighbors and a dread to acquaintances, being forgotten by some and slandered by others (25: 16-22; 31:9-13). God is portrayed as not being repulsed by these admissions of shame. The Psalmist cries out confidently believing God will hear and respond favorably (31:2,22; 34:6, 15f,; 119:145f.,163f.) in spite of these realities. God is described as one who gives face to people by hearing, seeing and responding with compassion to deliver them "out of all their troubles," to come "near to the brokenhearted," to save "the crushed in spirit," and to redeem "those who take refuge in Him" (34:19-22).

The choice of openness, intimacy, confidence and trust in God is the hope of humanity, yet that is also acknowledged as having potential for a shaming experience rather than a blessing. Trust and intimacy with God is experienced as lovingkindness (25:6), pardon for iniquity (25:11), forgiveness of all sin (25:18), redemption (25:22), experiencing God as a rock of strength, a stronghold, a fortress, and a faithful guide (31:1f.; 37:23f.; 119:105, 169), salvation in the form of deliverance (37:39-40), a hiding place, and a shield (119:114).

The assurance is given that waiting on God will not lead to shame, but impatient actions that questions God's integrity will assuredly result in shame (25:3, 5, 21; 37:7f.; 119:43f.). Personal integrity is a condition of not being shamed (25:3, 21) and the result of trusting in God (34:13f ; 37:18f., 27f., 37; 119:1f.). The experience of the positive quality of "not being ashamed" is not an emotionless, sober experience but has positive emotional content such as rejoicing (31:7; 119:14), praise (34:1, 3; 119:161f.), delight (37:4; 119:16), thankfulness (37:11, 16; 119:7). generosity (37:21), and awe/reverence (119:120).

The deliverance by God is not pictured as a confining experience for the rescued but one that liberates and gives freedom from enemies who pursue their evil ways (25:20). Freedom is having one's "feet set in a large place" (31:8) to be able to "walk at liberty" (119:45). This emphasis is reflected in Psalm 4:1 where God's deliverance from distress is in the form of making room for the one distressed (NASB margin note).

Isaiah also refers to a confident absence of shame and announces an everlasting salvation that will wipe away shame and humiliation for eternity (45:17; see also Joel 2:26-27). The promise is predicated on God as a source of hope. All who trust or hope in others will be put to shame (45:22-25). The content of this everlasting salvation experience is described in Isaiah 61, the pivotal passage used by Jesus to

link His ministry to the Old Testament prophecies. The book of Isaiah begins with a description of Israel as a garden of embarrassment with trees of shame (1:28-29). Because of her choices, Israel was desolate (1:7) and God had hidden His eyes from her in embarrassment (1:15). Isaiah's vision was a call for Israel to change, to wash and remove shameful evil, to learn and do good (1:16-17). This vision included a promise of redemption (1:18-19) and a warning that to continue in unfaithfulness would result in powerlessness before the enemy (1:19) and shame (1:29). The book of Isaiah ends with a description of a new garden planted by God with trees of righteousness that bring glory to God; a place where garlands replace ashes, gladness replaces mourning, and praise replaces fainting (61:3). Instead of shame, a double portion of blessing is promised. Instead of humiliation, shouts of joy, everlasting joy will be heard (61:7). Isaiah 61 begins with a list of changes announced for powerless, hopeless people whose condition is shameful: the afflicted, the brokenhearted, the captives, the prisoners, and those who mourn. The promised change brought good news, binding for the brokenhearted, liberty for the captive, freedom for the prisoner, and comfort for those who mourn (61:1-2). This change is predicated on the power of God to restore Israel (59:1f.) and to send a Redeemer (59:20) who will fulfill the promise of Israel becoming once again an "everlasting pride to God (Psalm 60:15f.). The change from

shame to confidence results in renewed motivation. Instead of helplessness and hopelessness, the children of Israel can have confidence to "rebuild . . . raise up . . . repair" (61:4-9) that will become the new foundation for future generations. Isaiah describes this change with the people being unashamed to publicly display feelings--"rejoice greatly"--and to wear the public symbols--"garments of salvation, robe of righteousness, garlands and jewels"--that identified them with God, and the garden of men's lives will spring up to display righteousness and praise before all nations (61:10-11).

New Testament Shame Themes. Schneider asserts that shame occupies a less prominent place in the New Testament than in the Old Testament. He found the sense of shame as awe in only one reference and notes that, unlike in the Old Testament, there exist no holy places, no temple, no holy things, no unclean things, and a Savior who teaches His disciples to address God with the "undue familiarity of 'Abba' ('Daddy')" (115). However, he also acknowledges that the use of shame themes and not-ashamed themes in the New Testament is much more complex than appearances may suggest.

Not every example of a New Testament shame theme includes the Greek words translated by the English shame words. For example, the earliest miracle of Jesus, the wedding at Cana, is a response to the potential humiliation of the bridegroom (John 2) Another major shame theme is

Jesus' portrayal in all the Gospels as freely interacting with people whose condition was inherently shaming before the community: the blind, the beggars, the crippled, the tax collectors, the sick, adulterers, and, the lepers who had to live apart from community and call out their shame lest anyone come in physical contact with them. Jesus' ministry is in the form of both physical healing and the forgiving of sins. However, Jesus' personal ministry was also one of looking at, speaking to, and touching that addressed their shame with an unconditional love that did not objectify them but restored their face. His actions were deemed to be shameless and an embarrassment by religious leaders, who are generally portrayed in the Gospels as being shameless in that they "disregard justice and the love of God" (Luke 11:42) and practice "hypocrisy" that will be exposed to all in due time (Luke 12:1-3). Matthew and Luke report Jesus as publicly confronting them with their shameless hypocrisy in the form of multiple "Woe to you" statements (Matthew 23:1f., Luke 11:37f.).

Shame themes are prominent in nearly all of Jesus' parables i.e. the foolish builder on sand (Matthew 7:24f.), the shepherd who loses his sheep (Matthew 18:12-14), the humiliation of the unforgiving servant who had been forgiven much (Matthew 18:21f.), the tenants who humiliate their landowner by rejecting his son (Matthew 21:33f.), the embarrassment of a wedding banquet where the invited guests

refuse to come and the shameful have to be invited (Matthew 22:2f.), the foolish virgins who are humiliated by their lack of preparation (Matthew 25:1f.), the humiliation of the servant who did not want to be humiliated and chose to hide his talent (Matthew 25:14f.), the goats who were embarrassed by their uncaring choices (Matthew 25:31f.), the public humiliation of losing a symbolic coin (Luke 15:8-10), the lost son who was humiliated into his senses and his brother who was angered by his father's non-shaming acceptance (Luke 15:11f.), the shrewd manager (Luke 16:1-15), the rich man who humiliated Lazarus (Luke 16:19f.), the persistent widow who embarrassed a judge into actin (Luke 18:1-8), the shameless Pharisee and the tax collector whose sense of shame led him to the Kingdom (Luke 18:9-14).

In addition to these general shame themes, significant specific references to both shame and the condition of being unashamed are found. Several different Greek words are usually translated using English shame words. For the atima word group Arndt and Gingrich suggest "dishonor", "treat shamefully", "insult", "disgrace", and, "shame" (119). Jesus experienced atima in His hometown when His powerful teaching was considered incongruent with His humble origin (Matthew 13:57; Mark 6:4). Jesus experienced shame again when He was insulted by Jews who accused Him of having power by means of a demon (John 8:49). Jesus also used this term in a parable to suggest the additional degrading treatment

inflicted upon an already wounded servant who was sent to collect what was due after a first servant had returned beaten and empty-handed (Mark 12:4; Luke 20:11).

In Romans Paul also uses atima in explaining that human sinfulness is shameful and is rooted in shamelessness, a lack of moral restraint. He reasons that humanity has chosen to ignore the knowledge of God (1:18-21a, 28a) and to neither glorify nor thank God (1:21), resulting in humanity's futile thinking [from matiaoo "worthless"], and darkened heart (1:21; see also Ephesians 4:17). Paul emphasizes the result of sinful choices by repeating three times that "God gave them over" to impure lusts and dishonorable use of their bodies (1:24), to degrading and unnatural passions (1:26). and, to a depraved mind (1:28). Humans are portrayed as shamelessly participating in a long list of sinful actions without moral restraint and approving those who joined them in actions clearly identified as unrighteousness (1:29f.); actions which Paul elsewhere labels as "unfruitful deeds of darkness . . . disgraceful [aischron]" (Ephesians 5:11-12).

Paul carries his theological use of atima into I Corinthians where he contrasts the results from Adam's sinful choice and the righteous choice of the second Adam, Jesus. Like Adam, the human body is perishable, weak, natural. and dishonorable (15:42-44). However, the body made possible by the Second Adam is imperishable, powerful,

spiritual and victorious over death (15:42-44, 50f.). Christ's bodily resurrection demonstrates the reality of this spiritual body and provides the basis of the believer's confidence and hope while they wait and toil (15:58). Paul acknowledges that without the reality of Christ's resurrection no basis exists for such confidence and "your faith is worthless [from mataioo]" (15:17). In this context Paul uses entropan as shame in the sense of moral restraint and calls the Corinthian church to carefully choose their companions (15:33), to become "sober-minded", and to "stop sinning" (15:34). He appeals for order in the Corinthian church and uses shame in the sense of social restraint, calling them to conform to prevailing social customs regarding length of hair (11:14 atima; 11:6 aischros) and head coverings (11:4, 5 kataischuno).

The oneidos word group is translated by Arndt and Gingrich using the English words "disgrace", "reproach", "insult", "revile" (573). This was the "disgrace" that was removed by God's choice in Elizabeth's barrenness with the birth of John the Baptist (Luke 1:25). This is the term used to describe the ridicule experienced by Christ on the cross when he was insulted by the onlookers and by the two robbers for his apparent powerlessness (Matthew 27:44, Mark 15:32, see also Romans 15:3). Jesus used this term to warn the disciples that they would experience insults and disgrace as part of their identification with the Kingdom

(Matthew 5:11; Luke 6:22). The writer of Hebrews used the term to remind his readers that they had already been made a "public spectacle" through insults and their powerlessness to prevent their property from being seized. They endured by their confidence in the promise of having "a better possession and an abiding one" (10:32-34), an experience that the writer of Hebrews used to call for continued confidence and endurance (10:35-36). Habbakuk 2:4 is quoted, reminding the reader that faith is the essence of endurance and to give up faith is displeasing to God (10:37-38). He goes on to identify Moses as having chosen the "reproach of Christ" (11:23) and challenges the reader to bear Christ's "reproach" and endure to please God (13:13-16).

The Greek term aidos is translated by Arndt and Gingrich as "modesty", "reverence" and "respect" (21). It appears only once in the New Testament (I Timothy 2:9) in the sense of modesty, although a variant reading includes it at Hebrews 12:28 in the sense of reverence and awe. Bultmann notes that aidos fell into general disuse but had the sense of a "bashful fear" of breaking the connection between God and humans (169). Its opposite, hubris, is translated as insolence, arrogance (LXX Proverbs 11:2, 29:23), and mistreatment (II Corinthians 12:10). The term describes a basic respect for God, for authority, and for righteousness. Bultmann cites Philo's connection between aidos and eleutheria and parrhesia (170). Eleutheria is

translated as "freedom" and "liberty" as contrasted to the slavery of human corruption (Romans 8:21) and the bondage of the Mosaic law (Galatians 2:4; 5:1). This term is used in the New Testament to convey the sense of self-discipline, reasonableness, rationality, mental soundness, good judgement, and chastity (Arndt 249-250).

Parrhesia is a term that conveys an "outspoken frankness", a "plainness of speech that conceals nothing and eliminates nothing", an "openness to the public", "courage", "boldness", "fearlessness" in relation to people of high rank, and "fearlessness" in relation to God (Arndt 635-636). As in the New Testament, aidos has little role in early Christianity. Bultmann suggests that its use became a characterization of one's relationship to oneself (ie: self-respect) which put the term outside the New Testament focus on relationship to God and neighbor that was governed by faith [pisteuon] and love [agapon] (171).

The major Greek word group translated with English shame terms is aischune and its derivatives. As a noun it has the sense of modesty-shame that leads to a restraint of actions; an experience which comes to someone as "shame, disgrace, or ignominy" (Arndt 24-25). The verb form is found only in middle and passive forms as to "be ashamed" or to "be put to shame, be disgraced" (Ibid.).

Aischune is the most frequently, but not exclusively used term in the LXX for the Hebrew bosh and is freely

interchanged with epaischuno and kataischuno as intensive forms of being ashamed (Ibid. 281, 411). Bultmann contends that aischune is used not so much as a state of being as a sense of despair (as contrasted to rejoicing) from loosing a sense of trust or hope. The term conveys a profound sense of disillusionment as can be seen from other Greek terms used in parallel with the aischune word group (189), including: entrepo "to turn one back upon himself" (Analytical 142); trasso "mental agitation", "confounded" (Arndt 813), "to disquiet, affect with grief, anxiety" (Analytical 398); atimos "to dishonor, disgrace, shame", "humiliation" (Arndt 119); oneidos "reproach, insult" (Ibid. 573); katagelao "laugh at, ridicule" (Ibid. 410); epistrapho "to turn around" (Ibid. 301); apostrepho "to slight, reject, repulse" (Analytical 47), "alienation", "face turned away" (Arndt 99-100); ekleipo "failure of faith" (Ibid. 242); hatton "utter defeat" (Ibid. 350), "an inferiority" (Analytical 189); mataioo "to fall into religious error, to be perverted" (Analytical 259), "worthlessness", "futility" (Arndt 496-497); apollumi "to be destroyed, ruined, lost" (Ibid. 94); suntribanai "fig. a broken mental attitude" (Ibid. 801).

Paul uses aischune as motivation for social restraint to maintain propriety in worship according to prevailing customs regarding head coverings, length of hair, the sharing of food in the love feasts, and the silence of women in

the church (I Corinthians 11:4f., 14,22; 14:35). As moral restraint he finds it shameful to even think about the impure, immoral, and lawless things that are done by some, let alone to speak about things done in secret (Ephesians 5:3-5, 12, see also II Corinthians 4:2; Colossians 3:8; Romans 6:19,21). The term is also used in Jude as the lack of moral restraint among those who have replaced grace with a "licentiousness" (4) that is to their shame (13), corruption (10 NASB margin), and judgement (15).

Aischune is used in two Gospel's to record Jesus' warning to His disciples about the consequences of their being ashamed of Him or His words. If they were ashamed of Him or His words He would be ashamed of them when He returns in His glory (Mark 8:38; Luke 9:26; see also Matthew 10:33). While the Matthew text differs from Mark and Luke, they can be compared by making the confession of Christ parallel to being unashamed and denial of Christ parallel to being ashamed. All three Gospel texts suggest that following Christ will bring the power of shame to bear on the disciples to enforce social and familial conformity. Jesus' call to the disciples was to either reject the power of shame as social and familial conformity or to receive His shame response to their rejection of Himself and the Father (Matthew 10:34-37). In Mark this passage (8:38) is a concluding summary response to Peter's rebuke of what must have seemed like incredulous optimism on Jesus' part when He said

He would be killed and then rise again after three days. Peter's quick and strong rebuke of Jesus may be an example of his shame response to being identified with One who would speak such unbelievable words. Jesus is portrayed as inferring that it would be shame and their response to shame that would lead the disciples to either gain soul-life by the self-denying, cross-bearing, life-losing, world-losing way of Christ or forfeit soul-life by not accepting self-denial and cross-bearing and choosing life-saving, world-gaining ways that Christ Himself rejects (Mark 8:31-38; Luke 9:22-26). Schlier interprets this reorientation of self called for by Christ as a choice to "cease to be one-self." He paraphrases Mark 8:34 as:

> I must not confess myself and my own being, nor cling to myself, but abandon myself in a radical renunciation of myself, and not merely my sins. I must no longer seek to establish my life of myself but resolutely accept death and allow myself to be established by Christ in discipleship. (471)

The inference is that a disciple's reluctance to lose face before family and social system will be a barrier that must be penetrated if the disciple is not to lose face in the Kingdom. The writer of Hebrews recalls this same emphasis assuring his readers that neither Christ nor the Father is ashamed of those who live by faith (2:11; 11:16).

Paul emphatically declares that he is not ashamed of the Gospel since it is the source of true power (Romans 1:16). Neither is he ashamed of the personal consequences that his faithful life has brought to him, namely, imprison-

ment and sufferings (II Timothy 1:8-12) He expresses appreciation that Onesiphoris was not embarrassed by seeing him in chains (II Timothy 1:16). He contrasts a "spirit of timidity" with a spirit of "power and love and discipline" (II Timothy 1:7) which become the basis of not being ashamed and endurance for suffering (II Timothy 1:8). Paul contrasts shame and sophronismou "discipline" which Arndt and Gingrich suggest carries the sense of sound mental health (809). This further emphasizes the contrast of unashamed confidence with the painful mental experience of shame as disillusionment.

Paul is unwavering and uncompromising in his conviction of the need to be not ashamed of the Gospel. He warns Timothy that "if we deny Him He will also deny us" (II Timothy 2:12b), words no doubt based on Jesus' warning to His disciples. Paul proceeds to build a framework for Timothy's continued personal motivation for ministry based on the desire to be "unashamed" (II Timothy 1:15).

Paul is particularly critical of the shame of using money as motivation for ministry (I Timothy 3:3, 8; Titus 1:7, 11; see also I Peter 5:2). He is critical of anyone who has allowed their "appetite" to become their motivation for ministry and to their shame have "set their minds on earthly things" (Philippians 3:19).

If New Testament use of aischune is shame in the form of despair and disillusionment due to the loss of trust and

hope, then to be unashamed must be the experience of trust and hopefulness. Paul builds the logic of having such trust and hope in Romans 5 based on the grace of God that profoundly changes humanity's experience of God. He argues that through Adam's sin humans became "helpless" (5:6), "sinners" (5:8), "enemies" (5:10), subject to "death" (5:12. 14, 15, 17. 21), and, subject to "condemnation" (5:18). On the other hand, Christ's death and resurrection has made it possible for humanity to be "justified by faith" (5:1, 9, 16, 18), to have "peace with God" (5:1), to have "abundant grace" (5:2, 15, 17, 20), to "stand" and "exult" (5:3, 11, 15), to be "saved from the wrath of God" (5:9), to be "reconciled" (5:10, 11), to be "made righteousness" (5:19), and, to "have eternal life" (5:21). Christ's death and resurrection is the basis of the restoration of trust and hope.

Paul accepts that being unashamed of the Gospel and being confident recipients of these profound benefits of the Gospel will result in sufferings and hardships (5:3). However, the endurance of suffering is based on a hope that Paul affirms will not "disappoint," literally, ou kataischunei "does not put to shame" (5:5; see also, Romans 9:33; 10:11) Instead, the hope becomes the basis "for perseverance" (5:4), which elsewhere Paul makes the basis of the promise of reigning with Christ (II Timothy 2:12a). The experience of enduring suffering results in "proven character" and "hope." (5:4) This hope is not disappointing as a

present experience because it is based on having experienced "the love of God that has been poured out within our hearts through the Holy Spirit who was given to us." (5:5) This pouring out of the love of God has been accomplished (perfect passive of ekcheo) and provides the hope that we will be "not ashamed." It stands in direct contrast to Paul's understanding of humanity's experience of having become futile and worthless in reasoning as well as darkened in heart as a result of God's act of giving humans over to their sin (Romans 1:24, 26, 28).

Paul declares that the situation has completely changed. A "reconciliation" has been accomplished (Romans 5:10). Katellagemen, "reconciliation," is the aorist passive form of an intensive compound suggesting the thoroughness of the action that has been taken. The change from being ashamed to unashamed includes a declaration of a changed emotional outlook on life. Paul calls for his reader to "exult" in the "hope of the glory of God" (5:2) as well as in the "tribulations" that are the result of unashamed and faithful living (5:3). They are to "exult" in the accomplished "reconciliation" (5:10-11). Found thirty-five times in the New Testament, "exult" is used only by Paul; a term that Barrett calls a "triumphant, rejoicing confidence in God" (quoted in Reinecker 359).

Two key passages provide a further basis to clearly link the experience of 'being unashamed' to having 'confi-

dent boldness.' The first passage is found in Philippians 1:20. Paul begins his letter to the Philippians with an expression of his own confidence (1:6) in spite of the appearance of his incarcerated circumstances. He is confident in spite of the preaching of some from impure motives (1:15-17). He rejoices in his "earnest expectation" [from apokaradokia "to watch with the head stretched out, to keep an eager lookout" suggesting the opposite of a shameful face-saving posture (Analytical 42)]. This expectant attitude, based on resurrection hope, leads him to continue to work without shame [en oudeni aischunthesomai] and with "all boldness" [pase parrhesia] (1:20).

The same link between not being ashamed and confident boldness, parrhesia, is found in I John 2:28, where the believer is challenged to abide with "confidence" [parrhesian] and to "not shrink away from Him in shame at His coming" [me aischunthomen]. Parrhesia serves as a sub-theme of I John, appearing in every chapter except the first. These references suggest that parrhesia is not only an eschatological experience, but a present experience of not being condemned in conscience (3:21) and being free of fear (4:18) as well as in confident prayer to communicate with God while waiting for the return of Christ.

Parrhesia is the characteristic of having "outspokenness, frankness, plainness of speech that conceals nothing", "courage, confidence, boldness and fearlessness" to express

oneself (Arndt 635-636). In political usage parrhesia was considered to be the right of any citizen of the Greek polis. It was considered a great loss to lose that right of candid speech, yet it also took courage and boldness to use it. With that right came responsibility for, Schlier notes, parrhesia taken to extreme without restraint became shamelessness (872). It was truth claims that the citizen had the right and obligation to speak about with frankness and candor. Schlier suggests the opposite of parrhesia was flattery, adulation, as well as indulgence and revelry. These characteristics were considered to be dangerous for the welfare of the polis (873). In private usage, parrhesia was considered to be characteristic of true friendship that allows confident candor. Again, parrhesia used to excess, or with the wrong motives, became shamelessness. When used to excess in impudent or insolent speech to the gods it was labeled blasphemous and unrighteous (Schlier 873-874).

Parrhesia occurs only rarely in the LXX. Significant passages include Job 22:23-27; 27:9f. Job experiences the freedom to face God and speak with confidence [parrhesia] even though he was "cast down" (22:23, 30). His parrhesia presupposes righteousness before God and is expressed in a prayer form that includes the emotional experience of both joy and delight (22:26; 27:10).

Schlier notes the usage in John's Gospel where Jesus always works publicly (18:20f.), yet is concealed awaiting

His kairos (7:6-8). The populous adopted a secrecy about Jesus based on their "fear of the Jews" (7:13). Later, when the Jews asked Jesus to speak to them with parrhesia as to whether he was the Christ (10:24), His candor and frank response resulted in their attempt to stone Him (10:31).

In John's Gospel Jesus is portrayed as linking the coming of the "Spirit of truth" who will disclose what is needed to be known. Until that time Jesus' speech will continue to be "in figurative language" (16:13, 25). Only at the end as Jesus was explaining His death and eventual resurrection did they begin to understand His "plain speech" (16:29).

In I John parrhesia before God is the believer's characteristic state when their conscience does not condemn them (3:21). Having parrhesia is based on faith in Jesus as God's son and on loving one another (3:23). Parrhesia comes with the presence of the Spirit (3:24) and results in prayer that God will hear (3:22; 5:14, 15). Parrhesia is both a present experience and a future experience before God that is concomitant with having no shame or condemnation (2:28; 3:21); "simply a reflection of the fullness of the love of God for us in which we abide" (Schlier 882).

In Acts the disciples are characterized as having parrhesia that responds to Christ's call in the Gospels for unashamed faithfulness. Their bold candor in teaching and preaching appears immediately after Pentecost and is a

surprise to the Jewish authorities (2:29; 4:13). Such boldness sharply contrasts with their portrayal in the Gospels and appears to be a consequence of their new relationship with the Holy Spirit as was predicted by Jesus (John 16:13) The disciples' prayer for parrhesia suggests that they viewed it as a type of charism along with healing and signs and wonders. The Acts reports that their prayer was answered in dramatic fashion with the Spirit's presence and an immediate experience of parrhesia (4:29-30). Following this experience of boldness they were reprimanded, incarcerated and flogged, however they left that experience with their parrhesia intact "rejoicing that they had been considered worthy to suffer shame for His name" (5:41) determined to keep on preaching and teaching (5:42). The community of faith rallied in support in the face of the crisis forming an ecclesia where all goods were held in common and, no doubt, parrhesia was lived out (4:32f.). Luke appears to insert the Ananias and Sapphira pericope at this point to suggest the seriousness of violating the community's parrhesia. The community has covenanted together to voluntarily share property in common. Ananias and Sapphira withhold the truth from the community breaking parrhesia with the community and with God. Their violation is shown as serious in their immediate deaths, which might be labeled as caused by their shamed exposure before the community (5:1-10).

Although Luke does not mention that parrhesia was a specific qualification in choosing the seven assistants of the disciples, the context and the subsequent actions of both Stephen and Phillip hint that the phrase "full of the Holy Spirit and wisdom" is parallel to having parrhesia (6:3f).

Parrhesia characterizes Paul's early post-conversion experience (Acts 9:27-28) as well as his mature ministry (14:3; 18:26; 19:38; 26:26). Paul's theology of ministry is rooted in his own experience of parrhesia before God that is made possible by the Holy Spirit who brings freedom to openly face God's glory with one's face uncovered (II Corinthians 3:16-18). Parrhesia was the purpose of God in the Christ event through whom "we have boldness and confident access through faith in Him" (Ephesians 3:12). The believer's parrhesia before God provides the basis of parrhesia before humanity as well as an adequacy for ministry. Paul asks the Ephesians to pray for him that he would have more parrhesia before humanity (6:19f.) that would make possible the transformation of his hearers into bold witnesses of the hope of the Gospel (II Corinthians 3:16-18).

Parrhesia is a distinctive theme in the book of Hebrews. Believers are directed to maintain parrhesia by holding fast to it (3:6, 14). The freedom of parrhesia before God allows the believer to confidently come near the "throne of grace, that we may receive mercy and find grace

to help in time of need" (4:16). The believer's parrhesia before God is possible because of the "blood of Jesus" that "inaugurated" a new way for a living relationship with God (10:19-22). The believer's confident access to God becomes the basis of their bold confidence before others to confess their "hope", "hold fast", and to not "throw away" their faith but to actively stimulate one another in faith (10:23-24, 35).

Hebrews presents Christ as the "author" ("pioneer" NASB margin note) and the "perfecter" of the believer's parrhesia before God in His "despising the shame" of the cross (12:1-2). Christ's boldness in front of the witnesses to His shameful death is used to encourage the believer in their boldness before the "cloud of witnesses" and to encourage them to "not grow weary and lose heart" (12:3). The believer's faithful endurance then results in their "acceptable service with reverence and awe" (from adios, 12:28).

Schlier summarizes his study of parrhesia as follows:

> "He who is in Christ has found again freedom towards God and can approach God with confidence. He can stand before the Ruler and Judge free and erect, not lowering his head, able to bear His presence." (883)

His observation implies that parrhesia is a return to a characteristic of the relationship among Adam, Eve and God before the first act of disobedience. This renewed parrhesia forms the basis of relationships within the ecclesia while we wait for full restoration before God at

which time we can come before Him both with confidence and without shame.

Review of Selected Spiritual Well-Being Literature

The relationship between spirituality and emotional well-being has been the subject of numerous research studies with varying results. Spirituality has been variously operationalized in these studies as: membership in religious organizations, attendance at religious services, religiosity, orthodox religious beliefs, spiritual maturity, intrinsic or extrinsic religious orientation, among others. This wide range of constructs of spirituality combined with the studies various operationalizations of well-being make the results difficult to compare. Payne et al. in their review of the literature point out limitations on the generalizability of these studies in that college students have been primarily used as the research populations. The studies have not generally included psychiatric populations to test their constructs of mental illness. Gartner, Larson and Allen also call attention to the prevalence of "paper-and-pencil tests" in these studies over behavioral observations (6). Criticizing personality tests as having "limited psychometric reliability and validity" (15) they note that research using personality tests most often links religious commitment with psychopathology. In contrast, studies that report a positive correlation between religion and mental health most often used behavioral observations to measure

research results.

The reports of the positive correlation between spirituality and emotional well-being are not without critics. Ellis' Rational-Emotive Therapy, a treatment modality sometimes used in addiction and codependency therapy, is an example of such a direct challenge. Rational-Emotive Therapy locates psychological disturbances in irrational thinking. In The Case Against Religion Ellis defines mental health as the ability to make rational choices on issues of self-interest, self-direction, tolerance, acceptance of ambiguity and uncertainty, flexibility, acceptance of reality, commitment, risk taking, and, self-acceptance. For Ellis, religion is the personification of irrationality and is "obsessive-compulsive, motivated by anxiety and dire need" (4). In "Psychotherapy and Atheistic Values" Ellis states: "Devout, orthodox, or dogmatic religion is significantly correlated with emotional disturbance. . . . the less religious they are, the more emotionally healthy they will tend to be" (637).

Watson et al. report two related research studies, "Dependency, 'Irrationality,' and Community" and "Values, 'Irrationality,' and Religiosity," that challenge Ellis' construct assumptions built into the Irrational Beliefs Test. Inconsistencies were identified in the test's measurement of irrational beliefs in that some of the ten measured beliefs were positively correlated with some and

negatively correlated with other irrational beliefs. Watson et al. find common ground with Ellis in linking disturbed emotions to disturbed thinking, however, they note that the same belief can be viewed as rational or as irrational by differing world views. They argue that labeling a belief as irrational by one world view is insufficient cause to reject another world view that labels the same belief to be rational. Instruments designed to measure psychological constructs must consider the ideological bias resulting from not accounting for the potentially differing world views of the instrument creator and the subject.

The review of literature by Payne et al. focuses on the issues of religion's role in the prevention of mental illness and the promotion of mental health. Their review groups the literature under the headings of "Psychological Adjustment," "Social Conduct," and "Mental Illness" (3). They found an absence of longitudinal studies that would support causal connections between religion and psychological adjustment, but note the weight of the significant number of research studies have reported positive correlations. They report positive research correlations between religion and morale, coping, marital adjustment, hope, and a sense of meaning of life and purpose. They call attention to the ambiguous results from research on religion and self-esteem, noting a ideological bias between the humanistic construct of self-esteem in the testing instrument and

the religious sample's orthodox terminology of sin and guilt. Watson, Morris and Hood report in "Antireligious Humanistic Values, Guilt, and Self-Esteem" that when they controlled for this ideological bias and the guilt language of sin, the results positively correlated intrinsic religion and self-functioning. Watson, Morris and Hood follow this report with a five-part systematic research project on "Sin and Self-Functioning" using a population of male and female students in a Mid-South university. Controlling for construct bias, they found positive correlations of healthy psychological characteristics with intrinsic religious orientation including internal awareness, less depression, emotional empathy, less distress, belief in authority and equalitarianism. Intrinsic religion was negatively correlated with narcissistic exploitiveness, machiavellianism, and excessive individualism. A clue to unhealthy religiosity was also reported in that extrinsic religious orientation was associated with maladjusted self-functioning. Payne et al. conclude their review of the literature on religion and self-esteem stating, "When proper controls are exercised, there is little relation between a belief in sin and poor self-functioning. Self-esteem seems to be a component of a healthy religious orientation" (5).

Payne et al. review the results of "Religion, Lifestyles, and Mental Health," a longitudinal study of personality development in a sample of Morman college students by

Bergin et al. that suggests the preventive role of religion in adjustment. Subjects characterized as developmentally normal and resilient commonly reported "benevolent child rearing, smooth or continuous religious development, and mild religious experience" (6). They were in general conformity with parental faith and without typical adolescent rebellion and had a positive experience with religious institutions. Subjects whose childhood was more conflicted demonstrated either religious inactivity or divergence from parental religious norms and reported troubled personal development. Payne et al. note that a number of such troubled subjects reported having subsequent "intense religious experiences that compensated for deficiencies in their personalities" (6). However, some of these therapeutic results were short lived and the subjects experienced increased personality disturbance as part of a self-defeating pattern.

Payne et al. report that the literature of religion and social conduct demonstrates positive correlations between intrinsic religious orientation and prosocial conduct including: marital satisfaction, deterrence to divorce, sexual satisfaction within marriage, and, the prevention of premarital intercourse and pregnancy. Religion was found to be correlated with abstinence from alcohol and drugs, moderate use of alcohol and lack of abuse of mood altering chemicals, as well as recovery form such abuse and dependency primarily

through the religious program of Alcoholics Anonymous. Intrinsic religion was found to inhibit suicide and suicidal ideation.

In reviewing the role of religion in preventing mental illness, Payne et al. report that, "we do not have definite findings that link positive religious development with the prevention of mental illness" (10). They report the reviews of the research by Bergin, Judd and Lea that show mixed results and point out various methodological problems in the research. They conclude that, "the etiology of mental illness may include familial and biological factors that sometimes override psychosocial factors as religion" (11).

Payne et al. conclude that the literature suggests that intrinsic religious orientation can foster healthy psychological functioning. Intrinsic religiosity calls for a, "higher commitment, seeing religion as an end in itself, unselfishly lived with less regard for consequences than principle . . . greater concern for moral standards, discipline, consistency, conservatism, and resistance to external pressure to deviate" (11). They also warn that some forms of religiosity (i.e. extrinsic religiosity) is correlated with accepting if not encouraging maladjustment.

Gartner, Larson, and Allen's recent literature review, "Religious Commitment and Mental Health: A Review of the Empirical Literature," follows a pattern suggested by Bergin's earlier "Religiosity and Mental Health: A Critical

Re-Evaluation and Meta-Analysis." They note that Bergin's review had concluded that 47% of the studies found positive correlations between religiosity and mental health, 30% reported no relationship at all, and 23% found a negative relationship (6). Their own review of research reported positive correlations between religion and physical health, well-being, longevity, marital satisfaction, improved psychological functioning as well as avoidance of suicide, drug and alcohol abuse, delinquency, divorce, and depression. "Ambiguous or complex" relationships are reported between religion and anxiety, psychosis, self-esteem, sexual disorders, intelligence and prejudice. They note that the studies have generally not distinguished the type of religiosity (i.e. intrinsic vs. extrinsic) of the subjects studied, thus have not distinguished the differential relationship between type and anxiety. They also note the ideological bias in many instruments and the language of some conservative religious subjects.

They report various research that correlates positive relationships between religion and psychopathology including issues of authoritarianism, dogmatism, tolerance of ambiguity, rigidity, suggestibility/dependence and temporal lobe epilepsy. They also point out various critiques of the instrumental bias used in many of the studies that are prejudicial to religious conservatives and traditional religious beliefs.

Miller has recently reported the absence of research studies on the relationship of addiction and spirituality. The "biopsychosocial" studies of addiction are void of any reference to transcendence or spirituality, even spirituality that avoids any personal belief in a deity or religious practices. Miller notes that "most of the variability in the onset, process, and outcome of addiction remains unexplained at present, and we can ill-afford to ignore any class of variable with potential explanatory power" (11). This absence is particularly striking given the significant role that spirituality plays in Alcoholics Anonymous where recovery is not seen as possible without spirituality. Miller adds that the reported experience of Alcoholics Anonymous participants suggests a sudden change process that is not explained by the more gradual "appropriations of learning theory" (12). That is, reports of a transforming sudden reorientation of the addict is common enough to deserve research study. Miller suggests that spirituality may be viewed as a dependent variable that covaries with other variables in the addiction process--"successful treatment of addiction would be associated with improvements in spiritual functioning as well as medical status and psychological adjustment" (13). On the other hand, spirituality may be found to be a moderating variable that could be used to determine the most likely successful treatment plan for an addict or as a predictor of treatment outcome without

regard to type of treatment. Miller notes that spirituality might also be an independent variable that could suggest a particular spiritual process that impacts the course of addiction and treatment. He acknowledges that in its present state psychology is limited in its study of spirituality and the resulting character changes that are normative in addiction recovery but finds the area ripe for study and research.

In "Spiritual Well-Being: Conceptualization and Measurement," Ellison links the development of the Spiritual Well-Being Scale to Moberg's research on quality of life measures. It was widely accepted at the time that religious orientation had connections for life satisfaction as an integrating force. Moberg's construct divided spiritual well-being into two interrelated dimensions. The vertical dimension, religious well-being (RWB) relates to a stable belief in God and a sense of relationship to God. The horizontal dimension, existential well-being (EWB) relates to having a sense of self-identity, self-direction, and self-determination. Ellison observes that,

> it is the spirit of human beings which enables and motivates us to search for meaning and purpose in life, to seek the supernatural or some meaning which transcends us, to wonder about our origins and our identities, to require morality and equality. It is the spirit which systematizes the total personality and provides some sense of the emerging direction and order. The spiritual dimension does not exist in isolation from our psyche and soma, but provides an integrative force (331-332).

Ellison and Smith review the recent research that used the Spiritual Well-Being Scale (SWBS). In terms of physical health SWB was reported as positively correlated with the subject's self-perception of health and the subject's approximation to ideal body weight and negatively correlated to a subject's elevated blood pressure. They also report positive correlations between SWB and adjustment to physical illness, including: hemodialysis, coping with cancer, reduced anxiety in cancer diagnosis, hope in breast cancer patients, and, hardiness in AIDS patients. SWB was reported as negatively correlated with both the frequency and the impairment of pain in cancer patients, social isolation and despair in cancer patients, and, hopelessness in chronically ill patients. SWB was reported as influencing positive attitudes of nurses toward patients and nurses' sensitivity to patients' spiritual needs.

Ellison and Smith also report that studies using the SWBS have positively correlated SWB with measures of psychosocial well-being, including self-actualization, internal locus of control, hope, and, mental health in the elderly. Confirmatory results have reported negative correlations with psychopathology as indicated by the Minnesota Multiphasic Personality Inventory and instruments measuring depression, negative mood states, aggressiveness, and, conflict avoidance. Relational well-being has been positively correlated with SWB in terms of general assertiveness, self-

confidence, initiating assertiveness, and, the giving of praise and asking for help. SWB is reported as negatively correlated with measures of physical and passive aggression, dependency, and, passivity.

They report confirmatory correlations between SWB and measures for spiritual maturity, spiritual leadership, religiosity, the importance of religion, frequency of church attendance, frequency of family devotions, frequency of personal devotions, and, belief in God, as a causal agent. SWB is generally reported as higher for born-again Christians and those who have been Christians longer than those who are either ethical Christians or non-Christians. The SWBS did not distinguish between denominational affiliations.

Ledbetter et al. report in "An Evaluation of the Research and Clinical Usefulness of the Spiritual Well-Being Scale" that the SWBS has "ceiling effects" when measuring SWB in religious samples. This limits its clinical usefulness in discriminating SWB to subjects with low scores (49). In "An Evaluation of the Construct Validity of the Spiritual Well-Being Scale: A Confirmatory Factor Analytic Approach" Ledbetter et al. report little support for Ellison's two-dimensional model on which the SWBS was designed. They suggest that the SWBS is more complex than assumed by Ellison and caution that "[t]otal subscale scores for individuals may be similar but for different reasons. . . .

Therefore, caution should be exercised before norming the present version of the SWBS" (100).

The research literature on codependency and Adult Children of Alcoholic families does not include specific correlations of spirituality and recovery. Yet, the clinical observations are replete with references to spirituality as a key component of recovery. The literature does not imply that a particular spirituality is more helpful than another, but does suggest that not all spiritualities or religions are healthy (Arterburn; Booth; Bradshaw; Rinck). The description of healthy spirituality in the codependency literature implies a positive correlation with improved psychosocial functioning and recovery from the effects of codependency. Challenges to this assumption of the correlation of spirituality and recovery have been raised. For example, Katz and Liu critique the spirituality found in self-help groups as cultist practices that result in reduced individualism and conceptual abilities with high emphasis on conformity. They charge that self-help and Twelve-Step spirituality is fundamentalist in its emphasis on giving oneself up to a Higher Power. They offer that "the real key to salvation is not relinquishing control to a treatment program, or guru, or your Inner Child. The Highest Power lies within your own fully developed self" (23).

Summary of the Review of the Selected Literature

The review of literature suggests that codependency, internalized shame, and spiritual well-being are complex, multidimensional constructs that vary in intensity and appear to be interrelated. General measures of healthy psychosocial functioning are reported to be positively correlated with lower degrees of codependency, lower degrees of internalized shame, and higher degrees of spiritual well-being. Conversely, the same measures of healthy psychosocial functioning are reported as negatively correlated with higher degrees of codependency, higher degrees of internalized shame, and lower degrees of spiritual well-being.

Thus, codependency should be positively correlated with internalized shame and negatively correlated with spiritual well-being. Changes in the degree of codependency should predict changes in the same direction for the subject's degree of internalized shame and predict changes in the opposite direction for the subject's degree of spiritual well-being.

The review of biblical shame themes also suggests that shame is both a complex and multidimensional phenomenological experience. Shame is ubiquitous in biblical material and, as such, must be a major consideration in understanding humanity's relationship to God. Unfortunately shame has not been widely examined in theological and biblical studies.

Shame is shown to function as a healthy component in humanity's sense of awe and fear that leads to worship of God. Shame is a component in moral decision making, serving both to inhibit immoral choices and as a corrective for having made such choices. The paradoxical nature of shame is suggested in the shamefulness of being shameless.

On the surface, the biblical material does not clearly use terminology equivalent to the psychological construct of "internalized shame," yet the theme of "not being ashamed" is clearly portrayed in biblical material as a positive result of healthy spirituality. Behind Paul's view of "reconciliation" is the contrasting alienation of humanity that is experienced as a loss of face with God, an exposure of being stained, blemished, and defiled by sin. Sin is exposure for all to see that one has "missed of the mark." Reconciliation invites redeemed humanity's boldness and face to face intimacy with God. This reconciliation of restored relationship goes far beyond the issue of justification and makes possible improved psychosocial functioning as healthy spiritual formation.

This study uses codependency, internalized shame, and spiritual well-being as dependent variables to measure the effectiveness of the independent variable, participation in New Hope for Recovery, a twelve-step ministry of College Church of the Nazarene, to provide a ministry of healing and recovery.

CHAPTER 3: THE RESEARCH PROCESS

Design of the Study

The problem addressed by this study is the effectiveness of New Hope for Recovery as a method of pastoral care and spiritual formation for a self-identified population whose psychosocial and spiritual functioning have been impacted by dysfunctional family-of-origin experiences or by current dysfunctional relationships, i.e. codependency. The question asked by the study is: "Can the church utilize a twelve-step support group to be a healing community for those who find the codependency paradigm a meaningful way to describe their emotional pain and spiritual struggles?"

Reported clinical observations suggest the prevalence of codependency in contemporary society and link codependency with high levels of shame and a diminished sense of spirituality, i.e. a diminished appreciation for and sense of one's authentic-self. The use of denial, dissociation, control, and perfectionism for survival or meaning-making in past painful relationships continues for the codependent long after the need for the defensiveness ends. The patterns become normalized as a fear-based and shame-based way of life that can interfere with effective psychosocial and spiritual functioning. This interference can continue to exist in the lives of those who have confessed Christ as Lord and Savior.

The Twelve Steps of Alcoholics Anonymous have been adapted by hundreds of self-help groups for many other compulsive and addictive behaviors. The literature reported that twelve-step recovery groups have been effective in assisting codependents improve their psychosocial functioning and their sense of healthy spirituality. Originating from within Evangelicalism, the Twelve Steps were structured in a way to establish personal spiritual discipline incorporating traditional biblical teachings about the personal conduct of life that results in improved psychosocial functioning and spiritual maturity. The historic roots of the twelve-step model suggests its compatibility with an Evangelical theology of ministry.

The purpose of this study is to assess the relationship among and changes in codependency, internalized shame, and spiritual well-being over time in certain participants in New Hope for Recovery, a twelve-step ministry of College Church of the Nazarene, Olathe, Kansas.

Statement of Research Questions

The following research questions are addressed in this study, including an analysis of outside variables that may contribute to or explain changes between the pretest and posttest scores.

Research Question 1

What are the changes and correlations of changes in degree of codependency within the samples in the study?

Operational Question 1. What degree of codependency characterizes the samples in the study as measured by the pretest?

Operational Question 2. What degree of codependency characterizes the samples in the study as measured by the posttest?

Operational Question 3. What degree of change in co-dependency is measured in the samples between pretest and posttest?

Operational Question 4. What is the similarity of the degree of change in codependency among the samples?

Research Question 2

What are the changes and correlations of changes in degree of internalized shame within the samples in the study?

Operational Question 1. What degree of internalized shame characterizes the samples in the study as measured by the pretest?

Operational Question 2. What degree of internalized shame characterizes the samples in the study as measured by the posttest?

Operational Question 3. What degree of change in internalized shame is measured in the samples between pre-test and posttest?

Operational Question 4. What is the similarity of the degree of change in internalized shame among the samples?

Research Question 3

What are the changes and correlations of changes in degree of spiritual well-being within the samples in the study?

Operational Question 1. What degree of spiritual well-being characterizes the samples in the study as measured by the pretest?

Operational Question 2. What degree of spiritual well-being characterizes the samples in the study as measured by the posttest?

Operational Question 3. What degree of change in spiritual well-being is measured in the samples between pretest and posttest?

Operational Question 4. What is the similarity of the degree of change in spiritual well-being among the samples?

Research Question 4

What are the correlations of changes in codependency, internalized shame, and spiritual well-being within each of the samples in the study?

Methodology

This study utilized a quasi-experimental, nonrandomized comparison group pretest--posttest design, requiring various methodological issues to be addressed.

Population

New Hope for Recovery, the research population, had an average weekly attendance of 125 adults at the beginning of

this study. New participants entered the program each week as the result of referral by counselors, pastors, friends, as well as in response to announcements in newspaper, radio, church bulletin and church newsletter.

The Morsch/Brower Class, the largest adult Sunday School class in College Church, had a weekly average attendance of 125 adults at the beginning of this study. Volunteer participants from this class were the comparison population for this study.

Sample

The original sample, i.e. all participants who completed the pretest instruments, included: 30 New Hope participants who entered the Open Group Phase during the four-week period prior to the administration of the pretest, 23 New Hope participants who entered the Covenant Group phase during the four-week period prior to the administration of the pretest, and 32 participants in the comparison population who completed the pretest during the same four-week time period.

The research sample, i.e. all participants who completed the pretest and posttest instruments, included: 14 New Hope Open Group participants, 14 New Hope Covenant Group participants, and 10 from the comparison population.

The mortality sample, i.e. all participants who completed the pretest instruments but did not complete the posttest instruments, included: 16 Open Group participants,

9 Covenant Group participants, and 22 from the comparison population.

Instrumentation

The following instruments were used to operationalize the variables in this study:

The Spann-Fischer Codependency Scale (SFCS). SFCS (Appendix E) was developed from a literature review of the clinically observed characteristics of codependents that led the authors to define codependency as a, "psychosocial condition that is manifested through a dysfunctional pattern of relating to others. This pattern is characterized by: extreme focus outside of self, lack of open expression of feelings, and, attempts to derive a sense of purpose through relationships" (Spann and Fischer 27). The SFCS assumes that the characteristics of codependency range on a continuum from low to high with the high range identified with greater psychosocial dysfunction. Fischer, Spann and Crawford predicted that codependency would be positively correlated with depression, anxiety, external locus of control, femininity, parental control and enmeshment with family-of-origin. Negative correlations were predicted for self-esteem, masculinity, and family variables including parent-child communication, satisfaction, and parental support. Age, occupation, income, and intactness of family-of-origin were predicted to be unrelated to codependency (88-89).

Fischer, Spann, and Crawford report their research leading to the development of the current version of the SFCS, a sixteen-item questionnaire using a six-point Likert-type scale for response. They hoped SFCS could be used to asses risk for psychosocial adjustment problems, the progress of treatment and recovery, and to facilitate research (97).

Fischer, Spann, and Crawford report that SFCS's reliability has been demonstrated across samples including two student groups (alpha = .73 and alpha = .80), Al-Anon group members with three or more years of involvement (alpha = .77) and Al-Anon/Codependents Anonymous group members with a maximum involvement of one month (alpha = .77). They also point to consistency of mean codependency scores ($\bar{X}$ = 52.32, $\bar{X}$ = 51.55, $\bar{X}$ = 51.99) across three student groups (N = 192, N = 228, N = 218). Test-retest reliability for their fifteen-item version of SFCS was .87 and the current version is changed only by the addition of one item (91).

Factor analysis identified a four-factor structure that Fischer, Spann, and Crawford report as support for the content validity of the SFCS (92). SFCS results have been reported as unrelated to age, income, race, occupation, and family-of-origin intactness (93-94). While social desirability influences SFCS results, high codependency scores would also indicate codependents who were countering social

desirability (94). The SFCS is correlated as predicted with depression, anxiety, external locus of control, femininity, masculinity, self-esteem, and family variables for the females. Family variables for males with maternal support were significantly correlated with codependency, but in the direction opposite the prediction suggesting that more maternal support for males relates to higher codependency scores (94-95).

The Internalized Shame Scale (ISS). (Appendix F) Cook reports that his research on shame identified clinical observations on the negative emotional impact of having excess shame, suggesting that the experience of too much shame has variable dimensions of frequency and intensity. Clinical observations link excess shame to experiences of rejection in family-of-origin, significant losses in family-of-origin, and the use of addictive behaviors as defenses against painful feelings of shame. The use of addictive behaviors becomes an additional source of and reinforcement of shame. These experiences appear to influence the formation of a shame identity based on the internalization of shame. The conceptualization of having an internalized shame self-schema is distinguished from the experience of shame affect and shame emotions that are consistent with healthy psychosocial functioning ("Measuring Shame").

Cook's Manual for the Internalized Shame Scale (ISS) reports that the current version is a thirty-item question-

naire with a five-point Likert-type score for response. Twenty-four negatively worded items are used for the Shame Scale. Six positively worded items from the ten items in the Rosenberg Self Esteem Scale are embedded as a Self-Esteem subscale to correct for response set. Cook does not recommend using the Self-Esteem subscale as an independent construct measure (2). Factor analysis of the Shame Scale identified two subscales--Inferiority and Alienation--but noted that they are not independent and may not offer any additional information. The ISS also includes demographic information and questions to assess family-of-origin information (1).

Cook claims reliability for the ISS based on alpha reliability for Shame Scale in a non-clinical college sample (alpha = .95 N = 645) and in a combined clinical sample (alpha = .96 N = 370). Test-retest reliability coefficients were .84 for the Shame Scale over a nine week period using graduate students (N = 44) (Manual 2).

Discriminant validity for the ISS is claimed using correlations in research studies with clinical and non-clinical samples using the ISS and other measures of self-esteem, depression, anxiety, anger, eating disorders, social desirability, and remembered experiences in family-of-origin.

Convergent validity is suggested by predicted and significant correlation ($p < .001$) of the Shame Scale with

measures of self-esteem and self-concept including: Tennessee Self Concept Scale (r = -.66 Total Score and r = -.62 Personal Score; N = 116), Coopersmith Self-Esteem Inventory (r = -.52; N = 92), Janis-Field Feeling of Inadequacy Scale (r = -.77; N = 186), Multiscore Depression Inventory, Low Self-Esteem (r = .68; N = 193), Eating Disorder Inventory, Ineffectiveness (r = .79; N = 113), and the Rosenberg Self Esteem Scale (r = -.74; N = 85). All samples were non-clinical except the Rosenberg sample who were male psychiatric inpatients (Ibid. 3). Cook argues that self-esteem scales are in fact measuring internalized shame (Ibid. 7).

Predicted Shame Scale correlations with depression are reported as r = .75 in a non-clinical sample (N = 193) using the Multiscore Depression Inventory. Using the Beck Depression Inventory (BDI), clinical samples of male psychiatric inpatients (N = 108) and psychiatric outpatients (N = 78) were correlated with the Shame Scale at r = .66 and r = .79 respectively. Cook advises that the significant correlation ($p = <.0000$) of BDI depression categories and the Shame Scale suggest that Shame Scales above 60 should be considered possible cases of clinical depression (Ibid. 4).

Additional significant Shame Scale correlations are reported for Trait and State Anxiety as well as Trait and State Anger (Ibid.), "weight preoccupation" and "high body dissatisfaction" (Ibid. 5), as well as remembered parenting that was characterized as being "low care and high protec-

tion [intrusion, control]" (6). Cook notes that the ISS was not influenced by social desirability as measured by the Marlowe-Crowne Social Desirability Scale (Ibid. 5). In "Measuring Shame" Cook reported that his early research supported positive correlations of the Shame Scale and addictive behaviors (213), however he qualifies this in the ISS Manual, "relative to other diagnostic groups, alcohol and drug dependent subjects experience somewhat less intense levels of shame" (7).

The Spiritual Well-Being Scale (SWBS). SWBS (Appendix G) was conceptualized out of the perceived need for an empirical measure of the role of religion and transcendence as continuous variables in assessing subjective well-being and predicting psychosocial risks (Bufford, Paloutzian, and Ellison 57). Ellison suggests that the "need for transcendence" is one of several basic needs that must be satisfied for there to be an experience of subjective well-being. "This refers to the sense of well-being we experience when we find purposes to commit ourselves to which involve ultimate meaning for life. It refers to a non-physical dimension of awareness and experience which can best be termed spiritual" ("Conceptualization" 331).

SWBS consists of a twenty-item questionnaire using a six-point Likert-type scale for response. In addition to the overall Spiritual Well-Being (SWB) score, Ellison identifies two subscales measuring Religious Well-Being (RWB)

and Existential Well-Being (EWB). Ellison qualifies SWBS as not measuring "spiritual health," or "spiritual maturity" (Ibid. 330).

Ellison reported SWBS test-retest reliability as .93 SWB, .96 RWB, and .86 EWB after one week, high internal consistency (alpha = .89 SWB, alpha = .87 RWB, alpha = .78 EWB), and predicted correlation with the UCLA Loneliness Scale, Purpose in Life Test, Intrinsic Religious Orientation, and self-esteem (Ibid. 333-335). Bufford, Paloutzian, and Ellison also report test-retest and internal consistency studies that support the reliability of the SWBS (57-58).

Discriminant validity is reported by Bufford, Paloutzian, and Ellison based on their review of previous factor analysis of SWBS as well as reported positive correlations with "several standard measures of well-being" and negative correlations with "indicators of ill health, emotional maladjustment, and dissatisfaction with life" (58). However, Ledbetter et al. examined the construct validity of SWBS using a Confirmatory Factor Analysis (LISREL) on archival data in two previous studies (N = 604). Their examination suggests that Ellison's two-factor conceptualization of RWB and EWB did not fit the results and that the SWBS may be more factorially complex than previously assumed ("Evaluation" 100). They suggest that their results do not invalidate the construct validity of SWBS overall, but caution is justified in interpreting similar scores for SWB or either

subscale in that the scores may be similar for different reasons ("Evaluation" 99).

Ledbetter et al. separately report on archival study of seventeen studies that utilize the SWBS to determine if ceiling effects limited the usefulness of the instrument. They report apparent ceiling effects when used with religious samples in that the scale was able to measure SWBS total scores four standard deviations below the sample mean in all samples, but in only two samples was SWBS able to measure total scores two standard deviations above the sample mean. They conclude that despite the ceiling effects and suggestions for further revisions "[the] SWBS has demonstrated an excellent ability to measure low scores, those that have traditionally been viewed as clinically significant, across a wide range of religious beliefs and practice" ("Clinical Usefulness" 53-55).

Data Collection Procedures

The nature of the population and samples limited the use of an experimental design. While random samples were not feasible, efforts were made to minimize the effect of demographic differences among the samples chosen.

All new entrants in New Hope for Recovery were routinely required to participate in a four-session Orientation Group before joining an Open Group. Ideally all new entrants would have completed the pretest instruments before participation in the Orientation Group to control for test

bias from the information discussed. However, it was determined that asking volunteers to take the pretests before the Orientation Group sessions could discourage participation in the New Hope ministry.

The research population included the new participants in the Open Group phase and Covenant Group phase of New Hope for Recovery who began during a four week period preceding the administration of the pretest and who volunteered for the study. Ninety-five percent of eligible Open Group participants and 100 percent of the eligible Covenant Group participants completed the pretest instruments.

The Comparison Group included volunteers from the largest adult Sunday School class in College Church of the Nazarene. As with the research population, the nature of the instruments was not revealed to the comparison population, however all participants knew that the data was being gathered for a research project.

Approximately eighteen months after the administration of the pretest, the same instruments were administered as a posttest. All participants completing the pretest instruments were requested in person or by mail to complete the posttest instruments. Postage was provided for mail response to encourage completion of posttest instruments.

Variables

The independent variable in this study was participation in the New Hope for Recovery group. Dependent vari-

ables measured in this study, the construct variables tested by the research instruments, included codependency, internalized shame, and spiritual well-being.

Two of the instruments included subscales measuring secondary dependent variables that their authors had identified as related to primary dependent variable being tested. The Internalized Shame Scale included subscales for Shame, Esteem, Alienation, and Inferiority. The Spiritual Well-Being Scale included subscales for Religious Well-Being and Existential Well-Being.

Control Issues

The study controlled for extraneous variables thought to have a relationship to the dependent variables including age, sex, marital status, religion, ethnicity, education. The study also controlled for certain family-of-origin experience variables including pre-age eighteen parental alcohol abuse, pre-age eighteen parental death, pre-age eighteen parental divorce or permanent separation, and pre-age eighteen experience of two or more months in a foster home.

To control for extraneous variables that might influence the outcome of the independent variable, the posttest requested additional data for the period between the pretest and posttest including percentage of participation in New Hope, participation in other twelve-step groups, participation in group or individual counseling, inpatient psychiatric treatment, changes in church worship attendance, change

in church attended, and intentional changes in spiritual practices, i.e. Bible reading, prayer, meditation, journaling, fasting, others reported by the participant.

Limitations due to research mortality were controlled by eliminating the pretest results for any participant in the sample who did not complete the posttest instruments. This resulted in a segmentation of the participants into an Original Sample, i.e. all who completed pretest instruments, Mortality Sample, i.e. only those who completed the pretest instruments, and a Research Sample, i.e. those who completed both pretest and posttest instruments.

Statistical regression due to extreme scores was controlled in statistical analysis by eliminating extreme scores, however the samples may represent an extreme as convenience samples.

Controls were not included for other extreme sample characteristics, e.g. reading disability, psychotic conditions or mood disorders, developmental disorders, intelligence quotient, extreme childhood ritual abuse, presence of or changes in medications, life crises (i.e. separation, divorce, remarriage, grief) or active suicidal ideation. These and other uncontrolled variables limit the results of this study and its generalizability.

Data Analysis

The Statistical Package for the Social Sciences (SPSS/-PC+) was used for descriptive and inferential analysis of

the data resulting from the research. The choice of statistical methods of inferential analysis was dependent upon the type of data under analysis as well as the distribution and variance of the sample. Parametric methods generally require that the assumptions of normal distribution and equal variances be satisfied (Leedy 184-185; Norusis 455; Popham 269). The samples in this study were small in size and were not randomly selected. Normal distribution and equality in variance could not be assumed, limiting the use of parametric methods of inferential analysis.

This study used nonparametric methods of analysis that did not require the assumptions of normal distribution or equality in variance. Nonparametric methods are generally considered less powerful than parametric methods in that nonparametric methods require larger sample sizes to reach equal levels of significance. Nonparametric methods are generally less likely to reject a hypothesis than a parametric method designed for the same purpose (Leedy 208). However, Popham notes that statistical significance that supports the rejection of the hypothesis by nonparamentric methods "has a very high probability of being statistically significant when using a parametric statistic" (271). The opposite is not necessarily true which limits the generalizability when the nonparametric method does not support the rejection of the hypothesis.

This study used instruments that collected nominally and ordinally measured data. The instruments included Likert-type response sets that are ordinal in nature but which are often treated as interval data and were treated as such in this study (Davies 162). Statistical significance in this study was reported when $p < .05$.

The Mann--Whitney U Test and the Wilcoxon Rank W Test were used to assess the similarity of the groups in the samples. These are nonparametric methods used with interval data to measure if differences exist between a dependent variable and an independent variable classified in two different ways (Popham 272). Popham notes that the Mann-Whitney U Test is similar to the parametric t-test and can be used "with little loss of power efficiency" (276). These tests can be used to determine if two independent samples are from the same population as measured by the same variable.

The Wilcoxon Matched--Pairs Signed--Ranks Test was used to assess the direction and magnitude of changes in dependent variables between the pretest and the posttest. The test is appropriate for a pretest--posttest design as the same subjects are measured in both and pretest--posttest and their responses can be matched.

The Spearman Rank--Order Correlation Coefficient was used to assess the degree of relationship of the groups in the sample on dependent variables.

CHAPTER 4: RESEARCH RESULTS

This chapter reports the data gathered from the completed pretest and posttest instruments including a description of the samples studied and an analysis of the significant results that respond to the research questions.

Participant Response

The purpose of this study was to assess the relationship among and changes in codependency, internalized shame, and spiritual well-being over time in certain participants in New Hope for Recovery, a twelve-step ministry of College Church of the Nazarene, Olathe, Kansas. All participants in all samples completed consent forms indicating their willingness to complete both the pretest and posttest sets of instruments [Appendix H]. Approximately eighteen months after the administration of the pretest instruments, the posttest instruments were sent to the Original Sample i.e. each person who had completed pretest instruments. A postage paid return envelope was provided and a second notice was sent to encourage response.

To control for response mortality the Research Sample included only those completing both the pretest and posttest. The participants in the Original Sample who did not complete the posttest instruments were designated as the Mortality Sample.

Table 1

Descriptive Statistics--Original Sample

Descriptive	New Hope Open Group	New Hope Covenant Group	Comparison Group
Sample Size:	30	23	32
Age: Mean	40.7	41.5	37.0
SD	8.8	10.2	4.6
Sex: Male	10	5	16
Female	20	18	16
Marital Status:			
Single	6	1	0
Married	19	8	31
Divorced	2	4	0
Remarried	1	4	1
Separated	1	5	0
Widowed	1	1	0
Cohabitation	0	0	0
Religion:			
Catholic	1	1	0
Protestant	26	18	32
Other/None	3	4	0
Ethnic:			
Black Af/Am.	1	0	0
Hispanic	0	1	0
White/Cauc.	29	22	32
Education: HS Diploma	2	3	1
Some College	14	12	4
Assoc. Degree	1	0	2
Bachelor's	9	5	14
Master's/plus	4	3	11

Table 1 reports the descriptive characteristics of the original sample. Tables 23, 24, and 25 in Appendixes I, J, and K compare the descriptive characteristics of the original sample, mortality sample, and research sample.

Response mortality was significant: 53 percent (N = 16) for the Open Group, 39 percent (N = 9) for the Covenant Group, and 69 percent (N = 22) for the Comparison Group. Significant results of response mortality included the elimination of all single participants from the Research Sample's Open Group and changes in the ratio of males to females in the Comparison Group (16:16 to 6:4). The relative relationship of the other descriptive characteristics appeared less affected by the mortality response.

The mortality sample was subjected to analysis using the same tests as on the research sample and original sample. The results were consistent with the results from the other samples and did not contribute any significant additional data. Those results are not included in this study.

Profile of the Research Sample

This research project used a quasi-experimental nonrandomized control group pretest-posttest design and attempted to minimize the effects of the nonrandomization of the sample by controlling for significant differences in the characteristics of the samples.

Table 2

Descriptive Statistics--Research Sample
Pretest Data

Descriptive	New Hope Open Group	New Hope Covenant Group	Comparison Group
Sample Size:	14	14	10
Age: Mean	40.5	45.0	38.8
SD	7.5	10.1	4.0
Sex: Male	5	2	6
Female	9	12	4
Marital Status:			
Single	0	1	0
Married	11	7	10
Divorced	2	2	0
Remarried	0	2	0
Separated	0	0	0
Widowed	1	1	0
Cohabitation	0	1	0
Religion:			
Catholic	0	1	0
Protestant	13	13	10
Other/None	1	0	0
Ethnic:			
Black Af/Am.	1	0	0
Hispanic	0	1	0
White/Cauc.	13	13	10
Education:			
HS Diploma	1	1	0
Some College	7	8	1
Assoc. Degree	1	0	1
Bachelor's	3	3	3
Master's/plus	2	2	5

Table 2 compares the research sample's descriptive characteristics on number of respondents, age, sex, marital status, religion, ethnic origin, and education.

The research sample was analyzed using the Whitney--Mann U Test and Wilcoxon Rank W Test to assess the similarity of groups on descriptive characteristics. The research hypothesis was:

> "The research sample groups are from the same population as measured by descriptive characteristics and posttest demographic data."

The hypothesis was generally accepted as the sample groups did not significantly differ on age and were similarly: married, Protestant, and White/Caucasian in ethnic origin. The hypothesis was rejected on comparing the ratio of male to female participants in the Covenant Group (2 : 12) to the Comparison Group (6 : 4). The hypothesis was also rejected on comparing the generally higher education level of the Comparison Group with both the Open Group and Covenant Group.

The research sample was analyzed using the Whitney--Mann U Test and Wilcoxon Rank W Test to assess the similarity of groups on the posttest demographic data displayed in Tables 3, 4, 5, and 6. The analysis confirmed that the Open Group and Covenant Group participants reported involvement in New Hope for Recovery at the time of completing the pretest instruments and that none of the Comparison Group reported involvement in New Hope before or during the study.

Significantly, only 2 of the 14 Open Group participants reported active participation in New Hope for Recovery at the time of the posttest; one with 1-25% involvement and the other with 76-100% between pretest and posttest. The 12 Open Group participants not active in New Hope for Recovery reported various involvement levels between pretest and posttest: 2 as 0%; 8 as 1-25%; 1 as 26-50%; and 1 as 51-75%. Seven Covenant Group participants reported active involvement in New Hope for Recovery at the posttest, all with involvement levels of 76-100% between pretest and posttest. The remaining 7 Covenant Group participants not active in New Hope for Recovery at the posttest also indicated various participation levels between pretest and posttest: 2 as 1-25%; 3 as 26-50%; and 2 as 76-100%.

Significant to the design of the study, the Open Group and Covenant Group participants were similar in their non-attendance of other 12-Step groups during the study and the Comparison Group reported no 12-Step group participation.

The Open Group and Covenant Group were similar in their ratios of participation in professional counseling (9 : 14, 8 : 14) during the study. In addition, 2 Covenant Group participants reported inpatient counseling during the study. These very similar levels of participation in counseling between the pretest and posttest made the Open Group and Covenant Group significantly different from the Comparison Group that reported no involvement in counseling.

Table 3

Posttest Demographics--Research Sample
Pretest and Posttest Data

Posttest Demographic Variable	New Hope Open Group		New Hope Covenant Group		Comparison Group	
Response	Yes	No	Yes	No	Yes	No
New Hope participant at pretest	14	0	14	0	0	10
New Hope participant at posttest	2	12	7	7	0	10
Participation in other 12-Step group	1	13	4	10	0	10
Participation in counseling	9	5	8	6	0	10
Inpatient treatment	0	14	2	12	0	10
Changed church attended	6	8	2	12	0	10
Attending College Church at posttest	1	13	6	8	10	0

Table 4

Posttest Demographics--Research Sample
Participation in New Hope for Recovery
Between Pretest and Posttest

Weekly Meeting Participation	New Hope Open Group	New Hope Covenant Group	Comparison Group
0%	2	0	10
1% - 25%	9	2	0
26% - 50%	1	3	0
51% - 75%	1	0	0
76% - 100%	1	9	0

Table 5

Posttest Demographics--Research Sample
Worship Attendance Patterns
Between Pretest and Posttest

Worship Attendance Pattern	New Hope Open Group	New Hope Covenant Group	Comparison Group
Started	2	1	0
Increased	0	6	0
Decreased	4	2	0
No Change	8	5	10

Table 6

Posttest Demographics--Research Sample
Spiritual Discipline Patterns
Between Pretest and Posttest

Number of Spiritual Disciplines	New Hope Open Group	New Hope Covenant Group	Comparison Group
1 Discipline	2	1	3
2 Disciplines	4	3	5
3 Disciplines	2	2	0
4 Disciplines	1	5	0
5 Disciplines	0	1	0

The posttest demographic data included behavioral changes consistent with changes in spirituality. Increased worship attendance during the study period was significantly different in the Covenant Group (N = 6) from the Open Group (N = 0) and Comparison Group (N = 0). The Open Group and Covenant Group also reported participants who started (N = 2, N = 1) or decreased (N = 4, N = 2) worship atten-

dance during the study period. More than 50 percent of the Open Group and Covenant Groups (N = 15) reported changes in worship attendance during the study period while none of the Comparison Group reported changes in worship attendance patterns.

There was also a significant difference between the Open Group (N = 1) and Covenant Group (N = 6) on attending College Church of the Nazarene at the time of the posttest. Both groups were significantly different from the Comparison Group's report of 100 percent attendance at College Church.

The Open Group (N = 9), Covenant Group (N = 12), and Comparison Group (N = 8) similarly reported having made "more intentional use" of one or more spiritual disciplines between the pretest and posttest.

Research Question 1: Codependency

What are the changes and correlations of changes in degree of codependency within the samples in the study?

Operational Question 1

What degree of pretest codependency characterizes the samples?

Pretest Codependency--Research Sample. Table 7 displays the pretest degree of codependency in the research sample using the means and standard deviations of scores measured by the Spann--Fischer Codependency Scale (SFCS). The SFCS has a six-point Likert-type response set with sixteen items for response. The minimum and maximum possi-

ble score was sixteen and ninety-six, with higher scores representing higher degrees of codependency. Norms have not been reported for the SFCS but mean scores across three college student samples were reported by Fischer, Spann, and Crawford as $\bar{X}$ = 52.32, $\bar{X}$ = 51.55, and $\bar{X}$ = 51.99.

Table 7

Codependency--Research Sample

Sample Groups	Pretest Scores	Posttest Scores	Changed Scores
Open Group			
N	14	14	14
Mean	66.64	51.57	-15.07
SD	12.88	10.90	12.14
Covenant Group			
N	14	14	13
Mean	63.00	54.07	-8.93
SD	13.96	11.47	6.96
Comparison Group			
N	10	10	10
Mean	44.60	47.40	2.80
SD	9.77	6.75	5.22

The Open Group and Covenant Group had similar pretest codependency mean scores ($\bar{X}$ = 66.64, $\bar{X}$ = 63.00) and standard deviations (SD = 13.41, SD = 13.96). The Comparison Group had a significantly lower pretest codependency mean score ($\bar{X}$ = 44.60) and narrower standard deviation (SD = 9.77). The New Hope groups' mean scores were higher and the comparison group's mean scores lower than those reported for student samples by Fischer, Spann, and Crawford.

Table 8

Significance of Difference--Dependent Variables
Research Sample

Paired Groups	Codependency		Internalized Shame		Spiritual Well-Being	
Test Data	Pre	Post	Pre	Post	Pre	Post
Open w/ Covenant	---	---	---	---	---	---
Open w/ Comparison	**	---	***	---	*	---
Covenant w/ Comparison	**	---	**	*	*	---

2-tailed * p < .05, ** p < .01, *** p < .001, **** p < .0001

Table 8 displays the statistical significance found by applying the Whitney--Mann U Test and the Wilcoxon Rank W Test to the pretest codependency scores to determine if the groups in the research sample were from the same population as measured by the degree of codependency. The research hypotheses were:

1. "The Open Group and Covenant Group are from the same population as measured by the degree of codependency."

2. "The Open Group and the Covenant Group are from populations that differ from the Comparison Group as measured by the degree of codependency."

The first research hypothesis was accepted for the similarity between the Open Group and Covenant Group ($p = .4663$) suggesting that they may be from the same population as measured by degree of codependency. The degree of statistical significance supported the second hypothesis

that the Open Group (p = .0010) and Covenant Group (p = .0025) were from populations that substantially differed from the Comparison Group in codependency.

Table 9

Family-of-Origin Variables
Research Sample

Variables	Open Group		Covenant Group		Comparison Group	
Responses	Yes	No	Yes	No	Yes	No
Father's Alcohol Abuse*	3	11	3	11	0	10
Mother's Alcohol Abuse*	1	13	1	13	0	10
Father's Premature Death	1	13	0	14	0	10
Mother's Premature Death	1	13	0	14	0	10
Parental Divorce/ Separation	1	13	3	11	0	10
Foster Home or Group Home Experience	1	13	0	14	0	10

* Original responses of "Very True," "Mostly True," collapsed to "Yes"; "Mostly Untrue," and "Very Untrue" collapsed to "No"

The literature review identified a preponderance of opinion that the degree of codependency is related to having had alcoholic parents or having experienced a personal life trauma before age eighteen. Six factors were requested as family-of-origin data with the Internalized Shame Scale: father's alcohol abuse, mother's alcohol abuse, father's

death, mother's death, parental divorce/separation and age of respondent at that time, and foster/group home experience and age of respondent at that time. The participant responses are displayed in Table 9. The Spearman Rank-Order Correlation Coefficient (r_s) was used to analyze the correlation of the family-of-origin variables with each group's pretest codependency scores. The correlations were not significant for any of the research sample groups.

Pretest Codependency--Original Sample. The original sample provided a significant data base for analysis of the pretest presence of the dependent variables. Table 10 displays the pretest degree of codependency of the original sample using the means and standard deviations measured by the Spann--Fischer Codependency Scale (SFCS).

Table 10

Dependent Variables--Original Sample

Samples	Codependency	Internalized Shame	Spiritual Well-Being
Open Group			
N	23	23	23
Mean	65.52	52.70	82.04
SD	14.24	20.01	13.73
Covenant Group			
N	30	30	30
Mean	66.27	54.37	79.33
SD	15.15	20.64	12.37
Comparison Group			
N	32	32	32
Mean	46.47	25.50	97.38
SD	11.04	16.93	11.74

* One case eliminated due to incomplete response.

As in the research sample, the Open Group and Covenant Group had similar pretest codependency mean scores ($\bar{X}$ = 65.52, $\bar{X}$ = 66.27) and standard deviations (SD = 14.24, SD = 15.15). Also, as in the research sample, the original sample's Comparison Group had a significantly lower pretest codependency mean score ($\bar{X}$ = 46.47) and a narrower standard deviation (SD = 11.04).

Table 11 reports the statistical significance found by applying the Whitney--Mann U Test and the Wilcoxon Rank W Test to the pretest codependency mean scores from the original sample to determine if the groups were from the same populations. The research hypotheses were:

1. "The Open Group and Covenant Group are from the population as measured by the degree of codependency."

2. "The Open Group and the Covenant Group are from populations different from the Comparison Group as measured by the degree of codependency."

The pattern of results reported for the research sample were similarly found in the original sample. The first research hypothesis was accepted for the similarity of the Open Group and Covenant Group (p = .7963) suggesting that they may be from the same population as measured by degree of codependency. The degree of statistical significance supported the second hypothesis that the Open Group (p = .0000) and Covenant Group (p = .0000) were from populations that substantially differed from the Comparison Group in codependency.

Family-of-origin demographic variables were analyzed against the original sample's pretest codependency scores, but were not significantly correlated.

Table 11

Significance of Difference--Dependent Variables
Original Sample

Paired Groups	Codependency	Internalized Shame	Spiritual Well-Being
Open w/ Covenant	---	---	---
Open w/ Comparison	****	****	****
Covenant w/ Comparison	****	****	****

2-tailed: * p < .05, ** p < .01, *** p < .001, **** p <.0001

Operational Question 2

What degree of posttest codependency characterizes the samples?

Posttest Codependency--Research Sample. Table 7 on page 144 displays the posttest degree of codependency of the research sample using the means and standard deviations as measured by the Spann--Fischer Codependency Scale (SFCS).

The Open Group and Covenant Group had similar posttest codependency mean scores ($\bar{X}$ = 51.57, $\bar{X}$ = 54.07) and standard deviations (SD = 10.90, SD = 11.47). The Comparison Group had a significantly lower posttest codependency mean score ($\bar{X}$ = 47.40) and narrower standard deviation (SD = 6.75).

Table 8 on page 145 displays the statistical significance found by of applying the Whitney--Mann U Test and

Wilcoxon Rank Sum W Test to assess the probability that the participants in the research sample's groups were from the same population as measured by degree of posttest codependency. In applying these tests after the intervention the research hypothesis was:

> "The sample groups are from the same population as measured by their posttest degree of codependency."

The hypothesis was accepted for all of the paired groups suggesting that they had become similar populations as measured by the degree of posttest codependency; a significant change from the pretest codependency correlations.

To control for the effects of certain variables outside the focus of this study, posttest demographic data were collected to assess possible influence on changes in dependent variables between the pretest and posttest. The data, reported in Tables 3, 4, 5, and 6 on pages 141 and 142, were used to analyze the correlation of the posttest demographic variables with each group's posttest codependency scores. Generally, correlations did not reach statistical significance. However, both the level of involvement in New Hope for Recovery sessions ($p = .0205$) and the involvement in professional counseling ($p = .0469$) between pretest and posttest were negatively and significantly correlated with the posttest codependency scores in the Open Group.

Operational Question 3

What degree of change in degree of codependency is measured in the research sample?

Degree of Change in Codependency. Table 7 on page 144 displays the degree of change in codependency means scores in the research sample. The negative mean score changes for the Open Group and Covenant Group ($\bar{X}_{diff}$ = -15.07, $\bar{X}_{diff}$ = -8.93) reflect substantial reductions in degree of codependency between the pretest and posttest.

Table 12 displays the results of applying the Wilcoxon Matched-pairs Signed-Ranks Test to analyze changes in codependency in the research sample groups. The research hypotheses were:

> 1. "The number of changes and magnitude of changes in codependency will favor reductions over increases in the Open Group and Covenant Group."
>
> 2. "The number of changes and magnitude of changes in codependency will be similar for reductions and increases in the Comparison Group."

Both hypotheses were accepted. The Open Group and the Covenant reported more cases of reductions (N = 11, N = 13) than increases (N = 3, N = 0) in codependency with one score tied in the Covenant Group. The frequency and magnitude of reductions was significant for the Open Group (p = .0033) and Covenant Group (p = .0015) and supported the acceptance of the first hypothesis. While the Comparison Group had more increases (N = 8) than decreases (N = 2) in codependency scores, the frequency and magnitude were not significant (p = .1688) which supported the second hypothesis.

Table 12

Significance of Changes in Codependency
Research Sample

Matched Paired Sample	Posttest less than Pretest	Posttest greater than Pretest	Posttest equals Pretest	2-Tailed p
New Hope Open Group	11	3	0	**
New Hope Covenant Group	13	0	1	**
Comparison Group	2	8	0	---

* p < .05, ** p < .01, *** p < .001, **** p < .0001

Table 13

Significance of Changes in Dependent Variables
Research Sample

Paired Groups	Codependency	Internalized Shame	Spiritual Well-Being
Open Group \w Covenant Group	---	**	---
Open Group \w Comparison Group	***	***	---
Covenant Group \w Comparison Group	***	*	---

2-tailed * p < .05, ** p < .01, *** p < .001, **** p < .0001

Operational Question 4

What are the correlations in the degree of change in codependency in the research sample?

Correlation of Change in Codependency. Table 13 displays the results of the Whitney--Mann U Test and Wilcoxon Rank Sum W Test analysis of the similarity of change in

codependency in the research sample. The research hypothesis was:

> "The degree of reduction in codependency is greater in the Open Group and the Covenant Group than in the Comparison Group."

The reductions in codependency in the Open Group and the Covenant Group were significant ($p = .0009$, $p = .0006$) compared to the increase in the Comparison Group. The correlation of reductions in codependency between the Open Group and the Covenant Group were not significantly different ($p = .1231$). The results supported the hypothesis.

A related research hypothesis was analyzed by comparing pretest scores with changes in scores:

> "The degree of pretest codependency is positively correlated with the degree of change in codependency"

The hypothesis was rejected for all groups. The Spearman Rank-Order Test results indicated that in the Open Group ($p = .0183$), Covenant Group ($p = .0199$), and Comparison Group ($p = .0353$) groups there was a statistically significant correlation, however the correlations were not in the direction predicted.

Research Question 2: Internalized Shame

What are the changes and correlations of changes in degree of internalized shame within the samples in the study?

Operational Question 1

What degree of pretest internalized shame characterizes the samples?

Pretest Internalized Shame--Research Sample. Table 14 displays the degree of internalized shame of the research sample using the means and standard deviations as measured by the Internalized Shame Scale (ISS).

Table 14

Internalized Shame--Research Sample

Sample Groups	Pretest Scores	Posttest Scores	Changed Scores
Open Group			
N	14	14	14
Mean	53.50	57.92	+4.42
SD	16.58	15.45	17.48
Covenant Group			
N	14	14	13
Mean	47.93	61.36	+13.43
SD	20.94	17.94	11.11
Comparison Group			
N	10	10	10
Mean	23.20	45.80	+22.60
SD	10.61	9.32	9.34

* - After controlling for noninvolvement in New Hope sessions.

The ISS uses a five-point Likert-type response set on thirty items. Cook's Manual directs the subtraction of one point from each response set before scoring. Twenty-four items are used for the Shame Scale with possible scores ranging from 0 to 96; higher scores representing higher internalized shame. The ISS includes a six-item embedded self-esteem scale, however Cook only recommends the Shame Scale for research (1, 2).

The Open Group and Covenant Group had similar pretest internalized shame mean scores ($\bar{X}$ = 53.50, $\bar{X}$ = 47.93) and standard deviations (SD = 16.58, SD = 20.94). In contrast, the Comparison Group had a significantly lower pretest internalized shame mean score ($\bar{X}$ = 23.20) and narrower standard deviation (SD = 10.61).

Cook's Manual cautions that the ISS is still experimental and clinical applications are limited, however norms are reported for internalized shame from reported research on various samples. Cook suggests that scores less than 50 indicate infrequent issues of internalized shame, scores from 50 to 59 indicate frequent experience of internalized shame, scores from 60 to 69 as indicate depression related to internalized shame, and scores 70 and above are consistent with "clinical indications of depression and/or other emotional or behavioral problems." According to Cook, scores above 60 generally indicate the presence of some relationship problem (8).

Table 15 displays the results of categorizing the individual pretest internalized shame scores in each group using Cook's suggested ranges. While "Infrequent Shame" was the largest single category in all groups, the percent of participant scores 50 and above was similar in the Open Group (57 percent) and the Covenant Group (50 percent). Both New Hope Groups were significantly different from the Comparison Group that had no pretest scores above 50.

Table 15

Classification of Internalized Shame
Research Sample

Shame Classification	Open Group		Covenant Group		Comparison Group	
Test Data	Pre	Post	Pre	Post	Pre	Post
Infrequent Shame	6	4	7	4	10	7
Frequent Shame	4	7	3	2	0	2
Depression, Shame	2	1	2	3	0	1
Clinical Depression	2	2	2	5	0	0

Table 8 on page 145 reports the statistical significance found by applying the Whitney--Mann U Test and the Wilcoxon Rank W Test to determine if the participants in the research sample's groups were from the same population as measured by their degree of internalized shame. The research hypotheses were:

> 1. "The Open Group and Covenant Group are from the population as measured by the degree of internalized shame."
>
> 2. "The Open Group or the Covenant Group are from populations that differ from the Comparison Group as measured by the degree of internalized shame."

The first research hypothesis was accepted for the relationship between the Open Group and Covenant Group ($p = .4760$) suggesting that they may be from the same population as measured by degree of internalized shame. The degree of statistical significance supported the second

hypothesis that the Open Group ($p = .0002$) and Covenant Group ($p = .0065$) were from populations that substantially differed from the Comparison Group on internalized shame.

Cook's ISS included six family-of-origin demographic variables often cited as contributing to adult psychosocial dysfunction. However, analysis did not exceed statistical significance on any family-of-origin demographic variable for pretest internalized shame scores.

Pretest Internalized Shame--Original Sample. Table 10 on page 147 displays the degree of internalized shame of the original sample using the means and standard deviations as measured by the Internalized Shame Scale (ISS). As in the research sample, the original sample's Open Group and Covenant Group had similar pretest internalized shame mean scores ($\bar{X} = 52.70$, $\bar{X} = 54.37$) and standard deviations ($SD = 20.01$, $SD = 20.64$). Also, as in the research sample, the Comparison Group's mean score ($\bar{X} = 25.50$) was significantly lower than both the Open Group and Covenant Group mean scores and a narrower standard deviation ($SD = 16.93$).

Table 16 displays the results of classifying the individual pretest scores of all groups in the original sample on the basis of Cook's suggested categories of shame scores. While "Infrequent Shame" was the largest single category for all groups, the percent of the Open Group (57 percent) and the Covenant Group (63 percent) having scores above 50 was significantly higher than the Comparison Group (10 percent).

This relationship was substantially the same as found in the research sample.

Table 16

Classification of Internalized Shame
Original Sample

Shame Classification	Open Group	Covenant Group	Comparison Group
Infrequent Shame	10	11	29
Frequent Shame	4	7	1
Depression, Shame	3	5	1
Clinical Depression	6	7	1

Table 11 on page 149 reports the statistical significance found by applying the Whitney--Mann U Test and the Wilcoxon Rank W Test to measure if the groups in the original sample were from the same population as measured by the degree of internalized shame. The research hypothesis was:

1. "The Open Group and Covenant Group are from the population as measured by the degree of internalized shame."

2. "The Open Group and the Covenant Group are from populations different from the Comparison Group as measured by the degree of internalized shame."

The pattern of results reported for the research sample were similarly found in the original sample. The research hypothesis was accepted for the relationship between the Open Group and Covenant Group ($p = .6995$) suggesting that they may be from the same population as measured by degree

of internalized shame. The degree of statistical significance supported the second hypothesis that the Comparison Group was from a population substantially different on Internalized shame than the Open Group ($p = .0000$) and the Covenant Group ($p = .0000$).

Analysis did not identify significant correlation for any of Cook's family-of-origin demographic variables and pretest internalized shame scores.

Operational Question 2

What degree of posttest internalized shame characterizes the samples?

Posttest Internalized Shame--Research Sample. Table 14 on page 154 displays the posttest degree of internalized shame of the research sample using the means and standard deviations measured by the Internalized Shame Scale (ISS).

The Open Group and Covenant Group posttest internalized shame mean scores were more divergent ($\bar{X} = 57.92$, $\bar{X} = 61.36$) than their pretest mean scores, yet both were significantly higher than the Comparison Group's mean score ($\bar{X} = 45.80$). The standard deviations ($SD = 16.58$, $SD = 20.94$) were similar but substantially larger than the standard deviation of the Comparison Group ($SD = 9.32$).

Table 8 on page 145 reports the statistical significance found by applying Whitney--Mann U Test and the Wilcoxon Rank W Test to assess the probability that the research sample groups were from the same population as mea-

sured by their degree of posttest internalized shame. In applying this analysis after the intervention the research hypothesis was:

> "The sample groups are from the same population as measured by their posttest degree of internalized shame."

The hypothesis was accepted for the similarity of the Open Group and Covenant Group ($p = .1976$), the same relationship as before the intervention. Unlike the pretest results, the Open Group and Comparison Group were insignificantly different ($p = .3189$) suggesting that the groups may be from the same population as measured by degree of posttest internalized shame. The hypothesis was rejected for the similarity of Covenant Group and the Comparison Group ($p = .0241$) indicating that the groups continued to represent populations that differed significantly in degree of posttest internalized shame even after the intervention; although the statistical significance was reduced from the pretest scores ($p = .0025$).

Analysis of posttest demographic data identified the frequency of participation in the New Hope for Recovery between pretest and posttest as positively and significantly ($p = .0009$) correlated with posttest internalized shame in the Open Group. Open Group participants with higher internalized shame scores were significantly more likely to have attended more New Hope sessions. Open Group participants with higher posttest internalized shame scores were also

positively and significantly correlated ($p = .0002$) with having seen a professional counselor between pretest and posttest.

Operational Question 3

What degree of change in degree of internalized shame is measured in the sample?

Degree of Change in Internalized Shame. Table 14 on page 154 displays the degree of change in internalized shame in the research sample between the pretest and posttest. Before controlling for nonparticipation, the Open Group had a reduction in internalized shame mean score ($\bar{X}_{diff} = -1.43$). However this was influenced by 2 participants who reported zero percent participation in New Hope for Recovery and a large negative mean change score ($\bar{X}_{diff} = -30.50$). Controlling for the nonparticipating cases, the Open Group had a mean score increase ($\bar{X}_{diff} = +4.42$). The Covenant Group's had significant mean score increase ($\bar{X}_{diff} = +13.43$). There was a significant and unexpected change ($\bar{X}_{diff} = +22.60$) in the Comparison Group's posttest mean score.

Table 17 displays the results of the Wilcoxon Matched-Pairs Signed-Ranks Test analysis of changes in internalized shame in the research sample's groups. The research hypotheses were:

1. "The number of changes and magnitude of changes in internalized shame will favor reductions over increases in the Open Group and Covenant Group."

2. "The number of changes and magnitude of changes in internalized shame will be similar for reductions and

increases in the Comparison Group."

The first hypothesis was rejected in that increased scores in the Open Group (N = 9) and in the Covenant Group (N = 12) exceeded the reductions (N = 3, N = 1). The frequency and magnitude of changes in the Open Group were not significant (p = .9499). While the Covenant Group's changes were significant (p = .0033), they were not in the predicted direction. The frequency and magnitude of changes in the Comparison Group were significant (p = .0051), but not in the predicted direction. Therefore the second hypothesis was rejected.

Table 17

Significance of Changes in Internalized Shame Research Sample

Matched Paired Sample	Posttest less than Pretest	Posttest greater than Pretest	Posttest equals Pretest	2-Tailed P
New Hope Open Group	3[a]	9	0	---
New Hope Covenant Group	1	12	1	*
Comparison Group	0	10	0	**

* p < .05 ** p < .01 *** p < .001 **** p < .0001
a - After controlling for noninvolvement in New Hope sessions.

Operational Question 4

What are the correlations in the degrees of change in internalized shame in the research sample?

Correlation of Change in Internalized Shame. Table 13 on page 152 displays the results of the Whitney--Mann U Test and Wilcoxon Rank Sum W Test analysis of similarity of change in internalized shame in the research sample. The research hypothesis was:

> "The degree of reduction in internalized shame is greater in the Open Group and Covenant Group than in the Comparison Group."

The degree of change in internalized shame was significant between the Open Group and Covenant Group ($p = .0100$), the Open Group and Comparison Group ($p = .0007$), and Covenant Group and Comparison Group ($p = .0222$). However, the hypothesis was rejected as all groups increased in internalized shame means scores. The results suggested that the three groups may represent different populations as measured by degree of change in internalized shame.

A related research hypothesis was analyzed by comparing pretest scores with changes in scores:

> "The degree of pretest internalized shame is positively correlated with the degree of change in internalized shame?"

The hypothesis was rejected as the correlations were negative and insignificant for all groups.

Research Question 3: Spiritual Well-Being

What are the changes and correlations of changes in degree of spiritual well-being within the samples in the study?

Operational Question 1

What degree of pretest spiritual well-being characterizes the samples?

Pretest Spiritual Well-Being--Research Sample. Table 18 displays the pretest degree of Spiritual Well-Being in the research sample using the means and standard deviations as measured by the Spiritual Well-Being Scale (SWBS).

Table 18

Spiritual Well-Being--Research Sample

Sample Groups	Pretest Scores	Posttest Scores	Changed Scores
Open Group			
N	14	14	14
Mean	79.35	92.36	+13.01
SD	11.52	16.21	12.84
Covenant Group			
N	14	14	14
Mean	84.79	92.79	+8.00
SD	14.53	19.19	10.34
Comparison Group			
N	10	10	9
Mean	97.60	103.40	+5.80
SD	8.48	8.18	4.80

The SWBS uses a six-point Likert-type response set and has twenty items. The possible scores range from twenty to 120, with higher scores representing greater spiritual well-being. Ledbetter et al. have reported that the SWBS may have ceiling effects that limit its use in discriminating high SWBS scores, but that it has shown ability to

discriminate among low scores.

As expected, the Open Group and Covenant Group had lower pretest spiritual well-being mean scores ($\bar{X}$ = 79.35, $\bar{X}$ = 84.79) than the Comparison Group ($\bar{X}$ = 97.60). The standard deviations in the Open Group (SD = 11.52) and the Covenant Group (SD = 14.53) were larger than in the Comparison Group (SD = 8.48). In context of concerns about ceiling effects in the SWBS, the pretest spiritual well-being mean scores were relatively high as a percentage of the maximum possible score of 120 (Open Group $\bar{X}$ = 66% of maximum, Covenant Group $\bar{X}$ = 71% of maximum, Comparison Group $\bar{X}$ = 81% of maximum).

Table 8 on page 145 displays the statistical significance found by applying the Whitney--Mann U Test and the Wilcoxon Rank W Test to determine if the groups in the research sample groups were from the same population as measured by their pretest degree of spiritual well-being. In this analysis the research hypotheses were:

> 1. "The Open Group and Covenant Group are from the same population as measured by the degree of spiritual well-being."
>
> 2. "The Open Group and the Covenant Group are from populations that differ from the Comparison Group as measured by degree of spiritual well-being."

The first research hypothesis was accepted for the similarity of the Open Group and Covenant Group (p = .3460) suggesting that they may be from the same population as measured by the degree of pretest spiritual well-being. The

degree of statistical significance supported the second research hypothesis that the Open Group ($p = .0011$) and the Covenant Group ($p = .0223$) were from populations that differed significantly from the Comparison Group on degree of pretest spiritual well-being.

Pretest Spiritual Well-Being--Original Sample. Table 10 on page 147 displays the pretest degree of spiritual well-being in the original sample using the means and standard deviations as measured by the Spiritual Well-Being Scale (SWBS). As in the research sample, the Open Group and Covenant Group had lower pretest spiritual well-being mean scores ($\bar{X} = 82.04$, $\bar{X} = 79.33$) than the Comparison Group ($\bar{X} = 97.38$). The standard deviations ($SD = 13.73$, $SD = 12.37$, $SD = 11.74$) were similar. Also, as in the research sample, the original sample's pretest spiritual well-being mean scores were relatively high as a percentage of the maximum possible score of 120 (Open Group $\bar{X} = 66\%$, Covenant Group $\bar{X} = 66\%$, Comparison Group $\bar{X} = 81\%$).

Table 11 on page 149 reports the statistical significance found by applying the Whitney--Mann U Test and the Wilcoxon Rank W Test to determine if the groups in the original sample were from the same population as measured by their pretest degree of spiritual well-being. The research hypotheses were:

> 1. "The Open Group and Covenant Group are from the same population as measured by the degree of spiritual well-being."

2. "The Open Group and the Covenant Group are from populations that differ from the Comparison Group as measured by degree of spiritual well-being."

The first research hypothesis was accepted for the similarity of the Open Group and Covenant Group ($p = .5122$) suggesting that they may be from the same population as measured by the degree of pretest spiritual well-being. The degree of statistical significance supported the second research hypothesis that the Open Group ($p = .0000$) and the Covenant Group ($p = .0001$) were from populations that differed significantly from the Comparison Group on pretest spiritual well-being.

Operational Question 2

What degree of posttest spiritual well-being characterizes the sample?

Posttest Spiritual Well-Being: Research Sample. Table 18 on page 164 displays the posttest degree of spiritual well-being of the research sample as measured by the Spiritual Well-Being Scale (SWBS). The Open Group and Covenant Group had almost identical posttest spiritual well-being mean scores ($\bar{X} = 92.36$, $\bar{X} = 92.79$), both lower than the Comparison Group's mean score ($\bar{X} = 103.40$). The standard deviations ($SD = 16.21$, $SD = 19.19$) were approximately double the Comparison Group's ($SD = 8.18$). Similar to the pretest results, the posttest spiritual well-being mean scores were even higher as a percentage of the maximum possible score of 120 (Open Group $\bar{X} = 77\%$, Covenant Group

$\bar{X}$ = 77%, Comparison Group $\bar{X}$ = 86%).

Table 8 on page 145 displays the statistical significance found by applying the Whitney--Mann U Test and the Wilcoxon Rank W Test to assess the probability that the research sample's groups were from the same population as measured by their posttest degree of spiritual well-being. In this analysis after the intervention the research hypothesis was:

> "The groups in the research sample are from the same population as measured by their posttest degree of spiritual well-being."

The research hypothesis was accepted for the similarity of the Open Group and Covenant Group ($p = .6955$), Open Group and Comparison Group ($p = .1275$), and the Covenant Group and Comparison Group ($p = .1063$). This degree of statistical significance suggested that following the intervention the groups had changed to populations that did not differ significantly in degree of posttest spiritual well-being.

The posttest demographic data were correlated with each group's posttest spiritual well-being score. A significant correlation was found between having participated in professional counseling during the study and having higher posttest spiritual well-being. Open Group and Covenant Group participants who were active in New Hope for Recovery at the end of the study had lower pretest spiritual well-being mean scores ($\bar{X}$ = 81.14, $\bar{X}$ = 71.00) than those who were not actively involved at the end of the study ($\bar{X}$ = 88.41,

$\bar{X}$ = 88.43). The same relationship held for the active participant's posttest mean scores ($\bar{X}$ = 89.57, $\bar{X}$ = 78.00) and the inactive participant's mean scores ($\bar{X}$ = 96.00, $\bar{X}$ = 94.75).

Operational Question 3

What degree of change was measured in the sample between the pretest and posttest?

Changes in Degree of Spiritual Well-Being. Table 18 on page 164 displays the degree of change in spiritual well-being mean scores in the research sample.

The positive mean scores change for the Open Group ($\bar{X}_{diff}$ = +13.01), Covenant Group ($\bar{X}_{diff}$ = +8.00), and Comparison Group ($\bar{X}_{diff}$ = +5.80) indicated an increase in spiritual well-being between pretest and posttest SWBS.

Table 19 reports the results of applying the Wilcoxon Matched-pairs Signed-Ranks Test to analyze changes in the research sample's spiritual well-being mean scores. The research hypothesis was:

1. "The number of changes and magnitude of changes in spiritual well-being will favor reductions over increases in the Open Group and Covenant Group."

2. "The number of changes and magnitude of changes in spiritual well-being will be similar for reductions and increases in the Comparison Group."

Table 19

Significance of Changes in Spiritual Well-Being
Research Sample

Matched Paired Sample	Posttest less than Pretest	Posttest greater than Pretest	Posttest equals Pretest	2-Tailed P
New Hope Open Group	2	12	0	**
New Hope Covenant Group	1	13	0	**
Comparison Group	1	8	1	*

* p < .05, ** p < .01, *** p < .001, **** p < .0001

The first hypothesis was accepted in that increases in the Open Group (N = 12) and the Covenant Group (N = 13) exceeded reductions (N = 2, N = 1). The frequency and magnitude of the changes were significant for both the Open Group (p = .0035) and the Covenant Group (p = .0092). The second hypothesis was rejected by the significance (p = .0051) of the Comparison Group's increases (N = 8) over reductions (N = 1).

Operational Question 4

What are the correlations in the degrees of change in spiritual well-being in the research sample?

Correlation of Change in Spiritual Well-Being. Table 13 on page 152 displays the results of the Whitney--Mann U Test and Wilcoxon Rank Sum W Test to assess the similarity of change in spiritual well-being in the research sample. The research hypothesis was:

> "The degree of increases in spiritual well-being is greater in the Open Group and Covenant Group than in the Comparison Group."

The hypothesis was rejected as the degree of change in spiritual well-being was not significantly different between the Open Group and Covenant Group ($p = .3226$), the Open Group and Comparison Group ($p = .1004$), or the Covenant Group and Comparison Group ($p = .4997$). The results suggest the three groups may represent similar populations as measured by degree of change in spiritual well-being.

A related research hypothesis was suggested in comparing pretest scores with changes in scores:

> "The degree of pretest spiritual well-being is positively correlated with the degree of change in spiritual well-being."

The hypothesis was accepted only for the Covenant Group, however, the correlation was not significant ($p = .3302$).

Research Question 4: Correlations of Change

What are the correlations of changes in codependency, internalized shame, and spiritual well-being within the samples in the study?

Operational Question 1

What are the correlations of the dependent variables in the research sample?

Correlations of Dependent Variables--Research Sample. Table 20 displays the correlations of the pretest and posttest measures of the dependent variables in the research sample using Spearman's method. The research hypotheses

were:

1. "The degree of codependency is positively correlated with the degree of internalized shame."

2. "The degree of codependency is negatively correlated spiritual well-being."

3. "The degree of internalized shame is negatively correlated with spiritual well-being."

Table 20

Correlations Among Dependent Variables
Research Sample

Dependent Variable Comparisons	Codependency with Internalized Shame	Codependency with Spiritual Well-Being	Internalized Shame with Spiritual Well-Being
Pretest Scores			
Open Group	.4683	-.4759	-.3410
Covenant Group	.7908***	-.7376***	-.8015***
Comparison Group	.7599*	-.1743	-.0183
Posttest Scores			
Open Group	.5841*	-.7116**	-.6296*
Covenant Group	.6483*	-.7417**	-.7287**
Comparison Group	.4141	-.0892	-.1927

* p < .05, ** p < .01, *** p < .001, **** p < .0001

The first research hypothesis was accepted in all groups for both pretest and posttest mean score correlations. Four of the six group mean score correlations were significant.

The second research hypothesis was accepted in all groups for both pretest and posttest mean score correlations. Three of the six group mean score correlations were significant.

The third research hypothesis was also accepted in all groups for both pretest and posttest mean score correlations. Three of the six group mean score correlations were significant.

Correlations of Dependent Variables--Original Sample

Table 21 displays the correlations of the pretest and posttest measures of the dependent variables in the original sample using Spearman's method. The research hypotheses were:

1. "The degree of codependency is positively correlated with the degree of internalized shame."

2. "The degree of codependency is negatively correlated spiritual well-being."

3. "The degree of internalized shame is negatively correlated with spiritual well-being."

Table 21

Correlations Among Dependent Variables
Original Sample

Dependent Variable Comparisons	Codependency with Internalized Shame	Codependency with Spiritual Well-Being	Internalized Shame with Spiritual Well-Being
Open Group	.7439**	-.5930**	-.6370**
Covenant Group	.7619**	-.6634**	-.7854**
Comparison Group	.7633**	-.4960*	-.6619**

* p < .05, ** p < .01, *** p < .001, **** p < .0001

All three hypotheses were accepted in all groups for all pretest and posttest mean score correlations. All eighteen of the group mean score correlations were significant.

Operational Question 2

What are the correlations of the changes in dependent variables in the research sample?

Correlations of Changes in Dependent Variables--Research Sample. Table 22 displays the correlations of the changes in measures of the dependent variables in the research groups using Spearman's method. The research hypotheses were:

1. "Changes in degree of codependency are positively correlated with changes in internalized shame."

2. "Changes in degree of codependency are negatively correlated with changes in spiritual well-being."

3. "Changes in degree of internalized shame are negatively correlated with changes in spiritual well-being."

Table 22

Correlations of Changes Among Dependent Variables Research Sample

Correlations of Changes	Codependency with Internalized Shame	Codependency with Spiritual Well-Being	Internalized Shame with Spiritual Well-Being
Open Group	.7142**	-.2533	-.2071
Covenant Group	.3544	-.4128	-.3624
Comparison Group	.5556	-.2840	-.2500

* p < .05, ** p < .01, *** p < .001, **** p < .0001

The first research hypothesis was accepted in all groups for mean score correlations. One of the three group mean score correlations was significant.

The second research hypothesis was accepted in all groups for mean score correlations, although none of the correlations were significant.

The third research hypothesis was also accepted in all groups for mean score correlations. None mean score correlations were significant.

Auxiliary Research Question

The posttest demographic data in Table 4 on page 141 includes the reported level of involvement in New Hope for Recovery between the pretest and posttest. The research design identified participation in New Hope for Recovery as the independent variable in the study. The research questions assumed that the Open Group and Covenant Group participants would have a similar levels of involvement in New Hope for Recovery between pretest and posttest and that their involvement would be significantly different from the Comparison Group's nonparticipation. However, a wide range in reported levels of involvement were reported in both the Open Group and Covenant Group.

To analyze the significance of involvement in New Hope for Recovery for changes in dependent variables, an involvement sample was extracted from the research sample. The New Hope participants in the research sample were combined. All Open Group and Covenant Group participants who reported New Hope involvement as 1-25% (N = 11) were identified as a Low Involved Group and those who reported 76-100% (N = 10)

as a High Involved Group. The research sample's Comparison Group (N = 10) was identified as the Not Involved Group. The involvement sample was submitted to analysis to determine if the level of involvement in New Hope for Recovery correlated with changes in the dependent variables.

The involvement sample was subjected to the same analysis as the research sample. The results did not differ significantly from those reported for the research sample. This was due in part to the significant number of Low Involved Group members also in the Open Group (N = 9) and High Involved Group members also in the Covenant Group (N = 9)

Summary of Research Results

The research confirmed that codependency and internalized shame are positively and generally significantly correlated and that both variables are negatively and generally significantly correlated with spiritual well-being as suggested by the literature review.

Analysis confirmed that the groups in the samples were similar on descriptive characteristics except for some variation in the ratio of male to female participants and varying levels of education. None of the descriptive characteristics were significantly correlated with dependent variable presence or change.

At the time of completing the pretest instruments the groups drawn from the New Hope for Recovery population were significantly different from the Comparison Group drawn from

the general adult population of College Church. New Hope participants had higher codependency and internalized shame mean scores and lower spiritual well-being mean scores. The dependent variables were not correlated significantly with parental alcoholism or family-of-origin trauma.

After the intervention, the New Hope groups had significantly lower codependency mean scores and higher spiritual well-being mean scores while the Comparison Group had only moderate mean score changes for these dependent variables. The internalized shame mean scores unexpectedly increased in all groups with significant increases for the Covenant Group and the Comparison Group.

The implications of the research results are discussed in the following chapter.

CHAPTER 5: DISCUSSION OF THE STUDY

This chapter presents a summary of the study, discusses the results of the research and the conclusions that are significant to the study, identifies limitations of the study, suggests implications for future research, and presents summary theological reflections.

Summary of the Study

The review of selected codependency literature traced the development of the construct from its theoretical and clinical sources. Codependency is a multidimensional psychosocial construct characterized by dysfunctional patterns of relationships. The construct, formulated primarily on clinical observations, has mixed research support and has not been generally accepted by the mental health community. Codependency is characterized as consistent with shame, internalized as part of one's self-schema, and with the absence of spiritual well-being. Recommendations for codependency recovery frequently include participation in twelve step groups such as Codependency Anonymous or Adult Children of Alcoholics.

The review of selected psychological literature on shame identified various theoretical formulations of shame. Shame has dimensionality from simple embarrassment and self-consciousness to inner torment of the soul. Universal autonomic characteristics of shame, include: blushing, lowering the head, and averting eye contact. Having a

'sense of shame' is linked to moral formation, but both the absence of shame and the internalization of shame as self-schema are linked to decreased psychosocial functioning. Recent literature has attempted to reformulate psychopathology as being shame based.

Shame themes in the literature of the Old Testament and New Testament were examined. Biblical terms for shame were examined and traced through the literature thematically. Shame was linked to the concept of sin as exposure of unfaithfulness to the covenant relationship graciously initiated by God; first in the Garden of Eden story and then repeated as the biblical story of God's humiliation by humanity. The humiliation of God by humanity is completed in the death of Jesus. Shame themes in Jesus' teaching and parables as well as in Paul's theology of reconciliation were examined. To be shameless was identified with evil, unfaithfulness, lawlessness, and without need for God. The encounter with the Holy was to experience shame and even to require shame in the sense of being powerless in the presence of almighty power. The construct of toxic or excessive shame is not an obvious biblical theme, yet, can be found when the healing pericopes of Jesus are examined from a shame paradigm. The alternative of being "unashamed and confident" because of the love and acceptance of God was examined as a biblical theme.

Selected literature on spiritual well-being was also reviewed, particularly as it correlated spiritual well-being and psychosocial functioning. While "recovering spirituality" is a common theme in the literature of codependency and addiction treatment, it is rarely operationalized. Moberg's construct of spiritual well-being includes both a religious dimension as relationship with God and an existential dimension as a sense of self-identity, self-direction, and self-determination. The review also included recent popular literature that questioned the assumption that spirituality always contributes to improved psychosocial functioning.

The study identified New Hope for Recovery, a twelve step support group ministry of College Church of the Nazarene, Olathe, Kansas, as an example of an attempt to serve as a healing community for a population who voluntarily self-identified as having codependency issues. New Hope for Recovery became the study's experimental population. A comparison population was identified from the adult Sunday School attendance of the same church who did not attend New Hope for Recovery.

Using a quasi-experimental, nonrandomized comparison group pretest posttest design, the study attempted to identify changes in degree of codependency, internalized shame, and spiritual well-being in the experimental population in contrast to the comparison population over

approximately an eighteen month period. The independent variable was identified as participation in New Hope for Recovery. In addition to the instrumentation to measure the dependent variables, the pretest and posttest measurements included various demographic questions to control for outside factors that might have a significant impact on the results of the study. The data was submitted to statistical analysis and reported.

Discussion of the Research Results

The large mortality response was unexpected and has been difficult to interpret. While it is a risk in all longitudinal studies, the relationship of the researcher as associate pastor and program leader to the sample appeared to assure high posttest response. Procedures were implemented to assure the anonymity of respondents to limit the influence of social desirability, however the personal relationship issue may have increased the mortality response. During the study, the researcher accepted a new ministry assignment in another state. Although the leadership transition in New Hope for Recovery was uneventful, the sample's feeling of abandonment or rejection may have influenced the sample to not complete the posttest instruments.

The New Hope population significantly differed from the church population on pretest codependency as expected based on the literature and the researcher's experience with both

populations. The results supported the discriminatory validity of the SFCS and were consistent with the results reported by the authors of the instrument. Confirmation that the church, through New Hope for Recovery, had provided a place that attracted people with substantial psychosocial challenges to feel free to self-identify that reality and to seek recovery was more significant.

The significant and positive correlation of codependency with internalized shame is important as a confirmation of reported clinical observations. The results support the discriminatory validity of the ISS. The strength of the correlation is also significant for the design of an effective intervention for codependency. Such intervention should account for the presence of an internal self-schema that resists seeing itself as anything except shameful and that defines success as hiding from exposure. The effective treatment of codependency requires a therapeutic paradigm that appreciates the significance of internalized shame and addresses it as a treatment issue.

The correlation of increased internalized shame with decreased codependency in the New Hope population during the period of the study was unexpected. Reviewing this correlation with the Congregational Reflection Group, participants in New Hope for Recovery but not the study, confirmed this as consistent with their recovery experience. They reported dealing with shame issues in "waves" that grew

in intensity as they were "working the program." They suggested that dealing with codependent behavior without facing their shame issues would have been another form of conforming and pleasing others instead of transforming recovery. Significant components of twelve-step programs require facing shame issues, e.g. requiring the admission of total "powerlessness over" a drug or some compulsive process; a leaderless model, i.e. no authority figure to shame others; small group accountability and sponsorship based on voluntary honesty; encouragement to publicly share one's story in an accepting peer environment; and the requirement to share a life inventory of wrongs with another human being in addition to God and yourself.

The significant increase of internalized shame in the comparison population was also unexpected. Nothing in the study accounted for this increase. Several comparison group participants, who became active in New Hope after the study, suggested that social desirability affected their pretest responses. Since the research had something to do with the "those people" in the New Hope group they answered the questions less than honestly to avoid appearing to be one of "them." These results suggest the need for additional longitudinal study of the stability of internalized shame and of the effect of group exposure to religious influences such as sermons, revivals, or fund raising appeals.

The SWBS discriminated the New Hope participants from the comparison population, however all SWBS scores were clustered at the high end of the scale. This supports the concern that ceiling effects limit the SWBS's power to discriminate among religious samples. The relative changes of posttest SWBS scores may have been distorted by this factor. The negative correlation of spiritual well-being with codependency and with internalized shame supports the clinical observations found in the literature. This correlation implies that the design of an effective intervention for codependency should account for the individual's past and present spirituality. Dysfunctional spirituality may inhibit effective recovery. Spiritual experience in shaming or abusive environments may affect one's ability to experience God as unconditionally loving and thereby limit codependency recovery unless the intervention includes the recovery of healthy spirituality.

The effectiveness of New Hope for Recovery as an intervention for codependents is suggested by the changes measured after the intervention. New Hope participants reported significant reductions in codependency correlated with increases in spiritual well-being. Changes in internalized shame were less theoretically consistent than the changes in codependency and spiritual well-being. Cook reported test--retest reliability validity up to ten weeks, however studies of longer periods have not been reported.

Changes in the internalized shame mean scores were significantly different between the two New Hope Groups and may reflect distinctions between early stage recovery in the Open Group and the later stage of "working the steps" in the Covenant Group. The apparent inconsistency of internalized shame scores after the intervention is particularly problematic if internalized shame is seen as a component of codependency rather than a separate but correlated issue. Increased internalized shame scores within the 'recovery' process is problematic if recovery is conceived as a linear and gradual progression. The literature suggested that various defense mechanisms, particularly denial, serve as barriers to both codependency and internalized shame recovery. Internalized shame was conceived as affecting the individual's identity formation and self-schema. Fossom and Mason, Potter-Efron, and others note that breaking the denial that has protected one from the pain of shame and reorganizing one's shame-bound self-schema may be a long-term process, yet it is not so much a gradual process as significant steps of change separated by periods of preparation for the next step. Recovery from shame-bound self-schema may require increased feelings of shame as one become's aware of its presence and makes the choices required to deal with its effects. The process of change may be "second-order change," as described by Watzlawick, Weakland, and Fisch, involving progressive steps that

"reframe" the sources and meaning of shame. This kind of nonlinear change, theologically labeled as regeneration, is identified in Allport's observation:

> [I]t sometimes happens that the very center of organization of the personality shifts suddenly and apparently without warning. Some impetus, coming perhaps from a bereavement, an illness, or a religious conversion, even from a teacher or book, may lead to a reorientation (quoted in Dunning 472).

As suggested by the literature review, codependency and internalized shame were positively correlated while both were negatively correlated with spiritual well-being. This inter-relatedness suggests that codependency prevention and recovery efforts should include a significant emphasis on acquiring the skills needed to maintain and repair what Kaufman labels the "interpersonal bridges" broken in shaming experiences or the "shame-bound" condition identified by Bradshaw, Fossom and Masson, and Potter-Efron. Further, the development of a healthy spirituality that addresses internalized shame would be consistent with the prevention of codependency and recovery from codependency.

Limitations of the Study

The generalizations from the study are limited by its use of convenience samples, small research sample and involvement sample size, social desirability, and the nonparametric methods used in the statistical analysis.

The possible influence of social desirability on the measurement of internalized shame may also extend to the

measurement of other dependent variables. For example, the support group's acceptance and affirmation of the participant's story of emotional pain and spiritual struggle may make it socially desirable to appear more, rather than less, codependent to the group. Also, the individual with high internalized shame may face the double-bind of internally identifying with the negative descriptions of codependency and low spiritual well-being while using grandiosity to present a non-shamed persona to the group.

Conclusions Significant to the Study

1. The New Hope for Recovery model of twelve step support group ministry can attract a population that varies significantly in degree of codependency from the general population of the sponsoring church.
2. As suggested by the literature, having higher degrees of codependency is consistent with having higher degrees of internalized shame and having lower degrees of spiritual well-being.
3. Recovery as measured by a reduction in degree of codependency is not directly related to levels of involvement in New Hope for Recovery. Recovery may be more related to the participant's on going cognitive dissonance with life as it has been experienced and their vulnerability to "reframing" or "regeneration."
4. Internalized shame and spiritual well-being appear to be related to codependency in important ways, but

are separate constructs. Changes in these variables also appear to be associated with, but not directly related to, codependency recovery.

5. The New Hope for Recovery model of twelve--step support group ministry can serve as a healing community for participants who identify codependency as a way to describe their emotional pain and spiritual struggles.

Recommendations for Further Study

A similar study should be pursued with larger randomized samples. An additional focus of such a study could be the correlation of more behavioral observations in addition to paper--and--pencil instruments to assess the dependent variables.

The typology of shame-based dysfunctional families may offer a model to analyze the dynamic process in a church organization. In The Addictive Organization Schaef and Fassel suggested that the dysfunctional family rules can characterize any organization, including the church. While the SWBS has been used to characterize different religious groups and congregations, no research has been found that attempts to determine if religious groups or churches can be differentiated by degree of codependency and internalized shame and their relationship to spiritual well-being.

The literature suggested that people-helping professions, including ministry, attract codependents. Ministers are not given a new set of coping skills upon

ordination, rather they bring to the challenge of ministry only the interpersonal skills learned to that point in life. Studies could be undertaken to determine whether a high percentage of pastors are from dysfunctional families and the impact of family-of-origin experience on ministry: Is there a correlation with ministry effectiveness or with leaving the ministry? Do pastors with limited psychosocial coping skills, e.g. authoritarian control, attract parishioners who are codependent on that control? If so. what is the impact on the spiritual functioning of the congregation and what are the implications for pastoral transitions?

How do church ministries that utilize a guilt paradigm of sin/salvation that does not take shame seriously differ from those ministries that have a shame/guilt paradigm of sin/salvation? In The Depleted Self Capps suggests that the theology of Western Christianity is limited by its acceptance of a guilt paradigm that excludes shame as a critical theological, biblical, and spiritual formation issue. He observes that the churches' message of the forgiveness of guilt falls on the deaf ears of those who experience their spiritual struggle in shame terms. Arterburn, Berry, Bradshaw, Taylor and Berry, and others have suggested that the message of the church at times reinforces and rewards codependent behavior rather than facilitating recovery.

The prominent role of shame issues identified in the literature review of biblical material suggests the need for related studies to critically analyze:

1. shame themes in historical and contemporary theological models;
2. the prominence of shame themes in past and current hermeneutical studies;
3. shame as a religious--psychosocial issue as viewed by pastoral theology and religious education;
4. the content and process messages of the church and their reception by codependent parishioners as well as those with higher internalized shame; and,
5. ministry forms that effectively address internalized shame as a barrier to healthy spiritual formation.

The unexpected increase in the Comparison Group's posttest internalized shame scores in this study suggests the need for longitudinal studies of internalized shame to answer questions about its variability over time. Some suggested questions include: How does the experience of embarrassment before completing the instrument affect the ISS scores? Is improved psychosocial functioning more consistent with attaining a low ISS score or with variability within a range of scores?

The suggested ceiling effects of the SWBS limit its usefulness within church samples, particularly evangelical

samples. Studies to remedy these limitations should continue with a greater research emphasis on application of the SWBS to other than Christian spirituality and other than spirituality in traditional religious groups e.g. twelve--step groups such as Alcoholics Anonymous, inpatient and outpatient clinical counseling groups in religious and non-religious settings.

Theological Reflections

The breadth and depth of the theological questions raised by this study are indicated by the suggestions for further study. If Western Christianity has not been blinded to a significant theological insight about the human predicament by a guilt paradigm that has not recognized the significance of shame, then theological integrity requires a answer to the question, "Why has shame been neglected in biblical and theological studies?" The call for such a revisiting the wells already dug may be perceived to be a call for revolution, which is the nature of paradigm shifts.

The issue of shame goes to the heart of the theological understanding of the human condition. The review of shame themes in biblical literature suggests that shame is not simply a modern psychologism of the human condition which might allow shame to be ignored by a theology that seeks to be biblical. On the contrary, any theology that has ignored the centrality of shame in explaining the nature of the human condition can hardly claim the approbation of

biblical.

Elaine Pagels' work with the historical treatment of the Garden of Eden story in Adam, Eve, and the Serpent questions the willingness of the church to accept Augustine's guilt paradigm of human nature for over 1600 years. She concludes the study with a question as to why humanity has a bias toward guilt; readily accepting guilt, labeling another as guilty, or blaming everything unexplainably negative on Adam's Fall. She suggests that the answer is found in the terror of facing the idea that suffering can happen without a cause, without anyone to blame. Pagels does not go on to put a name to that terrifying experience of facing unjust suffering. I would suggest that the experience of facing such unjust suffering is the very experience of shame--to feel abjectly powerless to change the course of suffering, to experience an injustice that cannot be remedied, or to realize one's absolute need to depend on a powerful Other for meaning. Humanity's need to find cause for suffering in the form of guilt is only the opposite side of our need to control. If the cause of the guilt can be discovered then one has the power to avoid that sin and avoid the guilt and thereby control the future to avoid suffering--to avoid shame.

It is argued by some that the term "codependency" is not a biblical term, yet Carder, Gernsey, and others have called attention to prominent biblical themes of

generational dysfunction in biblical material that portray the passing on of patterns of anxiety, abuse, and compulsive behaviors that affect family, community, and spiritual relationships. "Psychosocial functioning" is also not biblical terminology, yet the language of Paul's prayerful challenge for the Ephesian believers to "put off your old self which is being corrupted by its deceitful desires; to be made new in the attitude of your mind, and to put on the new self, created to be like God in true righteousness and holiness" (4:24 NIV) is consistent with changes that result in improved psychosocial functioning. Dr. David Thompson's research suggests that the categories of changes Paul describes in Ephesians 4:25 - 5:2 as part of the "new self" can be correlated, while maintaining the integrity to the original text, to the psychosocial challenges of what has come to be known today as codependency recovery. Central to the difficulty of addressing these issues theologically is the guilt paradigm that ignores the shame component of sin.

Theological systems that do not account for shame in describing the human condition are reductionistic given both the prominent role of shame themes in biblical material and the growing appreciation of shame's complex role in character formation, psychosocial dysfunction, and spiritual formation. The human condition and sin are reduced by such theological systems to problems of guilt. They posit that the salvation of humanity is circumscribed by justification,

i.e. the recovery of guiltlessness, which is conditioned on one's acceptance of God's freely offered forgiveness and commitment to faithfulness. This view allows the uncritical acceptance of an assumption present in many discipleship models: i.e. "Christians who have been truly forgiven for the guilt of sin do not struggle in their new life in Christ with issues of old emotional woundedness may have resulted in an internalized self-image of shamefulness." A logical corollary is that Christians who do struggle with such issues need to seek additional forgiveness for their remaining real guilt.

This reductionistic theology does not match the spiritual experience of many Christians. It's assumptions are challenged by many New Hope for Recovery participants who consistently testify of struggles with issues of self-worth and spiritual confidence long after they have experienced forgiveness for the guilt of sin. Others, writing from outside the recovery paradigm, also note the continuing struggles faced by believers. Given the state of our knowledge of biblical studies, psychology, and sociology, Ellens challenges the adequacy of a juridical understanding of sin which does not account for the "sickness" component in sin beyond guilt that impacts the psychosocial functioning of believers. The international acceptance of David Seamands' observations about the healing of painful memories that may remain in Christians and impair

their spiritual formation as well as his acknowledgement of the presence of compulsions for perfection found in some believers are also challenges to reductionistic views of sin. Booth, Melody, Rinck, and others challenge the reductionistic view of sin in their descriptions of frequent lifelong struggles of adult Christians who were victims of childhood abuse to find a loving, accepting image of God that frees them to experience grace. The common theme of the believers described by these and others is that as they have faced the sources of their internalized shame, apart from the issue of guilt, and found grace for shame that frees them to experience the unashamed confidence and boldness of parrhesia (I John 2:28 and others).

These challenges call for a new discipleship model that intentionally addresses the complex interrelationship of shame and guilt to sin and grace. One that recognizes spiritual formation as the formation of a self that may have been deeply wounded beyond the simplistic answers of forgiveness and commitment but not beyond the transforming power of grace. One that gives the church an effective means as a healing community to address the psychosocial and spiritual functioning of those who have been impacted by issues of internalized shame. The following anecdote describes the struggle of many who have shared their attempts to find a healing community in their church. After voluntarily mentioning his regular participation in four

support group meetings each week and his infrequent participation in his church's worship, a codependent explained:

> All you have to do to attend the group is admit that not everything is going well and that you are there to work on it. It seems to me that at church you can only attend if you can convince everyone that nothing is really wrong. I'd rather go where I feel accepted and encouraged.

If this is simply the experience of one person or even a few people it could be easily dismissed. Yet, if it is the common church experience of the large population who are adult children of dysfunctional families with deep emotional hurts, then such a church has ceased to be what Christ was--a healer of shame.

If, as Capps suggests, this is an age that no longer experiences their alienation from God in guilt terms but in shame terms, then a guilt limited message of the "Good News" misses the mark. The church that ignores the significance of shame would be guilty of a sinful closed-mindedness to the desperate needs of people and to the grace of God that is clearly portrayed in Scripture as God's response to humanity's disgrace. If that is a picture of the church, then many more will be looking for grace in another place where it is acceptable to not be acceptable.

"Lord, give us eyes to see and ears to hear and courage to choose the truth. Amen."

APPENDIX A

OVERVIEW OF NEW HOPE FOR RECOVERY

New Hope for Recovery is an adult support group model that utilizes a small group format and the Twelve Steps of Alcoholics Anonymous adapted to apply to codependency recovery. New Hope is designed to be open to the community without cost to participants. Attendance of the sponsoring church's worship services should be welcomed but not required for participation. The New Hope brochure describes the target audience as follows:

> New Hope is a 12-Step support ministry sponsored by (name of church) to support recovery from co-dependency, divorce, substance abuse, the long--term effects of sexual abuse, and dysfunctional families. Participation is designed to complement professional counseling and other support groups. If you grew up in an abusive home, a home that had an addicted member, or a dysfunctional family; if you have been affected by addictions or abuse in your life or family, you can benefit from New Hope. Members have experienced anger, a sense of lacking personal worth, inability to sustain personal relationships and frustration in attempting to live as a child of God.

The first New Hope for Recovery group began in September 1989 as an effort to meet the soul care needs of the growing, self-identified codependent population. New Hope, while adapting the Twelve Steps of Alcoholics Anonymous, is intentionally designed to not be an issue-specific group (in contrast to other issue-specific groups such as Alcoholics Anonymous, Narcotics Anonymous, or Codependents Anonymous) in order to avoid any sense of competition with already established issue-specific support groups. New Hope is

structured to complement concurrent participation in professional counseling or other support groups while providing a healing and nurturing environment to work on recovery and spirituality within the church community. The New Hope model encourages that basic child care be provided and a small group program for the elementary age children of New Hope participants to help the children build self-esteem and learn new coping skills.

The program is designed to allow new participants to enter any week and complete the first three phases in approximately 18 months.

Phase One: Orientation

Each new participant must attend the orientation sessions. The goals of these session include: information, breaking down isolation and 'terminal uniqueness, breaking the fear of the Don't Talk, Don't Feel, Don't Trust rules. The first three sessions are titled: "What is codependency?", "Where does it come from?", and "If God is so good, why do I feel so bad?" Each session includes a brief opening to welcome new participants, twenty minute video presentation, twenty minute leader presentation, and fifteen minutes in group dyads. The fourth session is designed to model the next phase of Open Group work.

Phase Two: Open Groups

These groups are 'open' in the sense that membership is not set from week to week. The goals of these sessions

include: experiencing breaking the Don't Talk, Don't Feel, Don't Trust rules from family-of-origin, breaking denial of the problems in the family-of-origin, becoming aware of patterns of problems in current relationships. The groups are leaderless but may have a volunteer facilitator who has completed the program. The twenty-five discussion guides examine the major characteristics of dependency and each of the Twelve Steps as modified for codependency. A sample is included in this appendix. After completing approximately twenty sessions, members can apply to be part of the next phase.

Phase Three: Covenant Group

These groups covenant to participant with the group members to work the Twelve Steps over thirty-five to forty sessions. Because these groups are closed and process at a deeper emotional level they should usually be sex distinct groups. The material used in this phase is a journal workbook based on the Twelve Steps that includes biblical references. Substantial journaling is done outside the session that becomes the basis for group sharing. Participants agree to rotate responsibility for moderating the group discussions. While all the steps will be discussed, at a practical level the unstated goal is for everyone to really accomplish the first five steps during the phase. This will become the basis for making the Twelve Steps a discipline of life rather than a task to get through.

Phase Four: Facilitator Training and Relapse Prevention

This phase is less structured and each participant is responsible to decide the level of continuing involvement that will be helpful for continuing their recovery. Some of the Covenant Groups may choose to stay together and do a book study of some recovery material. Periodically, material on relapse warning signs can be offered along with spiritual formation sessions on journaling, personality types and spirituality, or centering prayer experiences. For those who want to 'work their twelfth-step' by assisting in the Open Groups facilitator training can be offered to equip them with the skills needed to prevent relapse.

New Hope in Christ: Sunday School Class

The sponsoring church is encouraged to offer an adult Sunday School class that uses recovery material as the basis of the lessons. The leadership should intentionally use terminology similar to that used in New Hope for Recovery. This class can function as a safe side-door entrance to the church.

Ancillary Support Groups

It has been effective to add other groups as ancillary to the ongoing New Hope program. A six-week divorce recovery group or single parenting group can attract new members to these issue specific groups and introduce them New Hope as a place to continue in meaningful support after their group has concluded.

First Steps: Working Step Two

Step Two:

"Came to believe that a power greater than ourselves could restore us to sanity."

Scripture Reference:
"For it is God who works in you to will and to act according to his good purpose." Philippians 2:13

Believe
Greater
Restore
Sanity

Came to believe . . .

Many people find their perception of God was skewed by significant people in their lives. We must often "come to believe" correctly about God before we can trust Him as loving and with our best interest at heart.

What do you truly believe God feels for you as a person? Is your image of God negative or positive? Begin to seek evidence to back up and challenge your opinion of God.

. . . that a power greater than ourselves . . .

Believing in God does not always mean that we accept His power. Unless we let go of our distrust and begin to lean on God, we will continue to behave insanely. God is not a crutch for weak-willed people. All people must take steps to come to terms with their inability and God's ability to manage their lives.

Do you believe that God is capable of managing the life that you have not been able to manage?

What is your belief about God's power? (i.e. He uses it to keep bad people in line. etc.)

. . . could restore us to sanity."

No one likes to consider themselves "insane". Insanity has been defined as repeating the same action while expecting different results. Codependency and compulsions can result in our doing "insane" things.

Do you recognize that continuing to struggle with managing your own life in the same ways will not yield different results?

What would sanity be in your life? What would you do differently or stop doing altogether? What would you begin doing?

APPENDIX B

WEIGSCHEIDER-CRUSE'S CHARACTERISTICS OF CODEPENDENT BEHAVIOR

"Co-dependency is a lifestyle, a patterned way of relating to others. It's a way of interpreting experience. And it's a lifestyle with low self-esteem at the core.

Co-dependents suffer from a progressive focing of attention on a target and a concomitant neglect of one's own feelings and needs.

The co-dependent person leads a life characterized by:

- An inability to have spontaneous fun and the ability to let go.
- Problems with intimacy.
- Inability to know what normal behavior is.
- An exaggerated need for the behavior of others.
- Confusion about making choices.
- Anxiety about making changes.
- Black and white judgements.
- Fear and denial of anger.
- Lies and exaggerations.
- Fear of abandonment.
- Tendency to look for people to take care of.
- Need to control self and others" (Choicemaking 3).

APPENDIX C

WOITITZ'S CHARACTERISTICS OF ACOA

1. Adult children of alcoholics guess at what normal behavior is.

2. Adult children of alcoholics have difficulty following a project through from beginning to end.

3. Adult children of alcoholics lie when it would be just as easy to tell the truth.

4. Adult children of alcoholics judge themselves without mercy.

5. Adult children of alcoholics have difficulty having fun.

6. Adult children of alcoholics take themselves very seriously.

7. Adult children of alcoholics have difficulty with intimate relationships.

8. Adult children of alcoholics overreact to changes over which they have no control.

9. Adult children of alcoholics constantly seek approval and affirmation.

10. Adult children of alcoholics usually feel that they are different from other people.

11. Adult children of alcoholics are super responsible or super irresponsible.

12. Adult Children of alcoholics are extremely loyal, even in the face of evidence that the loyalty is undeserved.

13. Adult children of alcoholics are impulsive. They tend to lock themselves into a course of action without giving serious consideration to alternative behaviors or possible consequences. This impulsivity leads to confusion, self-loathing and loss of control over their environment. In addition, they spend an excessive amount of energy cleaning up the mess (xvii-xix).

APPENDIX D

CERMAK'S DIAGNOSTIC CRITERIA FOR CO-DEPENDENT PERSONALITY DISORDER

A. Continued investment of self-esteem in the ability to control both oneself and others in the face of serious adverse consequences.

B. Assumption of responsibility for meeting others' needs to the exclusion of acknowledging one's own.

C. Anxiety and boundary distortions around intimacy and separation.

D. Enmeshment in relationships with personality disordered, chemically dependent, other dependent, and/or impulse disordered individuals.

E. Three or more of the following:

1. Excessive reliance on denial
2. Constriction of emotions (with or without dramatic outbursts)
3. Depression
4. Hypervigilance
5. Compulsions
6. Anxiety
7. Substance abuse
8. Has been (or is) the victim of recurrent physical or sexual abuse.
9. Stress related medical illness
10. Has remained in a primary relationship with an active substance abuser for at least two years without seeking outside help (Diagnosing 11).

APPENDIX E

THE SPANN--FISCHER CODEPENDENCY SCALE

S.F.C.S

Read the following statements and place the number in the spaces provided that best describes you according to the following list:

1 = Strongly Disagree **2 = Moderately Disagree** **3 = Slightly Disagree**
4 = Slightly Agree **5 = Moderately Agree** **6 = Strongly Agree**

_____ 1. It is hard for me to make decisions.

_____ 2. It is hard for me to say "no."

_____ 3. It is hard for me to accept compliments graciously.

_____ 4. Sometimes I almost feel bored or empty if I don't have problems to focus on.

_____ 5. I usually do not do things for other people that they are capable of doing for themselves.

_____ 6. When I do something nice for myself I usually feel guilty.

_____ 7. I do not worry very much.

_____ 8. I tell myself that things will get better when the people in my life change what they are doing.

_____ 9. I seem to have relationships where I am always there for them but they are rarely there for me.

_____ 10. Sometimes I get focused on one person to the extent of neglecting other relationships and responsibilities.

_____ 11. I seem to get into relationships that are painful for me.

_____ 12. I don't usually let others see the "real" me.

_____ 13. When someone upsets me I will hold it in for a long time, but once in a while I explode.

_____ 14. I will usually go to any lengths to avoid open conflict.

_____ 15. I often have a sense of dread or impending doom.

_____ 16. I often put the needs of others ahead of my own.

APPENDIX F

THE INTERNALIZED SHAME SCALE

Today's Date:_____

ISS

Name:_____

GENERAL INFORMATION

Please provide the following information:

1. **Age** at last birthday:_____

2. **Sex** (circle one): Male Female

3. **Marital Status** (check one)

_____Single

_____Married

_____Divorced, single

_____Divorced, remarried

_____Separated

_____Widowed

_____Cohabiting (living with relationship)

4. **Religion** (check one)

_____Catholic

_____Protestant

_____Jewish

_____Other:_____

_____No religious affiliation

5. **Ethnic or racial identification** (check one)

_____Black/African-American

_____Native American

_____Hispanic

_____Oriental

_____White/Caucasian

_____Other:_____

6. **Highest level of Education**

_____Less than H.S. diploma

_____H.S. diploma

_____Some college, no degree

_____Associates degree

_____Bachelor's degree

_____Masters or beyond

Please turn the page for the ISS directions and items.

ISS

DIRECTIONS: Below is a list of statements describing feelings or experiences that you may have from time to time or that are familiar to you because you have had these feelings and experiences for a long time. Most of these statements describe feelings and experiences that are generally painful or negative in some way. Some people will seldom or never have had many of these feelings. Everyone has had some of these feelings at some time, but if you find that these statements describe the way you feel a good deal of the time, it can be painful just reading them. Try to be as honest as you can in responding.

Read each statement carefully and circle the number to the left of the item that indicates the frequency with which you find yourself feeling or experiencing what is described in the statement. Use the scale below. **DO NOT OMIT ANY ITEM.**

SCALE

1	2	3	4	5
NEVER	SELDOM	SOMETIMES	FREQUENTLY	ALMOST ALWAYS

SCALE

1 2 3 4 5 **1.** I feel like I am never quite good enough.

1 2 3 4 5 **2.** I feel somehow left out.

1 2 3 4 5 **3.** I think that people look down on me.

1 2 3 4 5 **4.** All in all, I am inclined to feel that I am a success.

1 2 3 4 5 **5.** I scold myself and put myself down.

1 2 3 4 5 **6.** I feel insecure about others opinions of me.

1 2 3 4 5 **7.** Compared to other people, I feel like I somehow never measure up.

1 2 3 4 5 **8.** I see myself as being very small and insignificant.

1 2 3 4 5 **9.** I feel I have much to be proud of.

1 2 3 4 5 **10.** I feel intensely inadequate and full of self doubt.

1 2 3 4 5 **11.** I feel as if I am somehow defective as a person, like there is something basically wrong with me.

1 2 3 4 5 **12.** When I compare myself to others I am just not as important.

SCALE

1	2	3	4	5
NEVER	SELDOM	SOMETIMES	FREQUENTLY	ALMOST ALWAYS

SCALE

1 2 3 4 5 **13.** I have an overpowering dread that my faults will be revealed in front of others.

1 2 3 4 5 **14.** I feel I have a number of good qualities.

1 2 3 4 5 **15.** I see myself striving for perfection only to continually fall short.

1 2 3 4 5 **16.** I think others are able to see my defects.

1 2 3 4 5 **17.** I could beat myself over the head with a club when I make a mistake.

1 2 3 4 5 **18.** On the whole, I am satisfied with myself.

1 2 3 4 5 **19.** I would like to shrink away when I make a mistake.

1 2 3 4 5 **20.** I replay painful events over and over in my mind until I am overwhelmed.

1 2 3 4 5 **21.** I feel I am a person of worth at least on an equal plane with others.

1 2 3 4 5 **22.** At times I feel like I will break into a thousand pieces.

1 2 3 4 5 **23.** I feel as if I have lost control over my body functions and my feelings.

1 2 3 4 5 **24.** Sometimes I feel no bigger than a pea.

1 2 3 4 5 **25.** At times I feel so exposed that I wish the earth would open up and swallow me.

1 2 3 4 5 **26.** I have this painful gap within me that I have not been able to fill.

1 2 3 4 5 **27.** I feel empty and unfulfilled.

1 2 3 4 5 **28.** I take a positive attitude toward myself.

1 2 3 4 5 **29.** My loneliness is more like emptiness.

1 2 3 4 5 **30.** I feel like there is something missing.

Please turn to the back page to complete family information items.

FAMILY INFORMATION

Below are a few questions about your family of origin experience before age 18. Please answer these questions as honestly as you can by checking the response category that is most accurate. (If you are not yet 18 years old, respond for the way things have been so far in your family.)

1. During the years before I was 18, my father had or may have had an alcohol abuse problem.

   ___Very true ___Mostly true ___Mostly untrue ___Very untrue

2. During the years before I was 18, my mother had or may have had an alcohol abuse problem.

   ___Very true ___Mostly true ___Mostly untrue ___Very untrue

3. My father died before I was 18 years old. ___Yes ___No

4. My mother died before I was 18 years old. ___Yes ___No

5. My parents divorced or permanently separated before I was 18 years old.

   ___Yes ___No

If you answered Yes, how old were you when your parents divorced? _____

6. Before I was 18 years old I spent two months or more in a foster home or a group home because of difficulty with my family.

   ___Yes ___No

If you answered Yes, how old were you when in the foster/group home? _____

If you have any comments about these questions or any of the items on the ISS please feel free to write them in the space below. If there is any other information about yourself that you think it would be important for a counselor or therapist to know you may add that information below.

APPENDIX G

THE SPIRITUAL WELL--BEING SCALE

S.W.B.S.

For each of the following statements circle the choice that best indicates the extent of your agreement or disagreement as it describes your personal experience.

SA = Strongly Agree MA = Moderately Agree A = Agree
D = Disagree MD = Moderately Disagree SD = Strongly Disagree

1.	I don't find much satisfaction in private prayer with God.	SA	MA	A	D	MD	SD
2.	I don't know who I am, where I came from, or where I am going.	SA	MA	A	D	MD	SD
3.	I believe that God loves me and cares about me.	SA	MA	A	D	MD	SD
4.	I feel that life is a positive experience	SA	MA	A	D	MD	SD
5.	I believe that God is impersonal and not interested in my daily situations.	SA	MA	A	D	MD	SD
6.	I feel unsettled about my future.	SA	MA	A	D	MD	SD
7.	I have a personally meaningful relationship with God.	SA	MA	A	D	MD	SD
8.	I feel very fulfilled and satisfied with life.	SA	MA	A	D	MD	SD
9.	I don't get much personal strength and support from my God.	SA	MA	A	D	MD	SD
10.	I feel a sense of well-being about the direction my life is headed in.	SA	MA	A	D	MD	SD
11.	I believe that God is concerned about my problems.	SA	MA	A	D	MD	SD
12.	I don't enjoy much about life.	SA	MA	A	D	MD	SD
13.	I don't have a personally satisfying relationship with God.	SA	MA	A	D	MD	SD
14.	I feel good about my future.	SA	MA	A	D	MD	SD
15.	My relationship with God helps me not to feel lonely.	SA	MA	A	D	MD	SD
16.	I feel that life is full of conflict and unhappiness.	SA	MA	A	D	MD	SD

17.	I feel most fulfilled when I'm in close communion with God.	SA MA A D MD SD
18.	Life doesn't have much meaning.	SA MA A D MD SD
19.	My relation with God contributes to my sense of well-being.	SA MA A D MD SD
20.	I believe there is some real purpose for my life.	SA MA A D MD SD

APPENDIX H

POSTTEST DEMOGRAPHIC FORM

ID Number_____

Post-test Demographics

1. At the time I completed the pre-test I was a participant in New Hope for Recovery at College Church.
   _____yes _____no

2. I am now a participant in New Hope for Recovery.
   _____yes _____no

3. Between completing the pre-test and this post-test I have participated in New Hope for Recovery approximately:

   _____0% of the weekly sessions
   _____ 1% - 25% weekly sessions
   _____26% - 50% weekly sessions
   _____51% - 75% weekly sessions
   _____76% -100% weekly sessions

4. Between completing the pre-test and this post-test I have:

   a) regularly participated in a 12-Step group other than New Hope for Recovery
      _____yes _____no

   b) participated in counseling (group, individual, or family) led by a mental health professional
      _____yes _____no

   c) experienced inpatient psychiatric treatment
      _____yes _____no

5 Between completing the pre-test and this post-test my church worship attendance pattern has:

   _____ 1) started attending worship services (I rarely attended before.)
   _____ 2) increased attendance at worship services
   _____ 3) decreased attendance at worship services
   _____ 4) stopped attending worship services
   _____ 5) no significant changes

6. Between completing the pre-test and this post-test I have changed the Church I attend.
   _____yes _____no

7. I am now attending College Church of the Nazarene.
   _____yes _____no

8. Between completing the pre-test and this post-test I have, separate from worship services, made <u>more intentional</u> use of the following spiritual practices:

   _____ Bible reading
   _____ prayer
   _____ meditation
   _____ journaling
   _____ fasting
   _____ other: _____

APPENDIX I

Table 26

New Hope Open Group Descriptive Statistics
All Samples - Pretest Data

Descriptive	Original Sample	Mortality Sample	Research Sample
Sample Size:	30	16	14
Age: Mean	40.7	42.4	40.5
SD	8.8	9.7	7.5
Sex: Male	10	5	5
Female	20	11	9
Marital Status:			
Single	6	5	0
Married	19	9	11
Divorced	2	2	2
Remarried	1	0	0
Separated	1	0	0
Widowed	1	0	1
Cohabitation	0	0	0
Religion:			
Catholic	1	1	0
Protestant	26	12	13
Other	3	3	1
Ethnic:			
Black Af/Am.	1	0	1
Hispanic	0	0	0
White/Cauc.	29	16	13
Education:			
HS Diploma	2	1	1
Some College	14	7	7
Assoc. Degree	1	0	1
Bachelor's	9	6	3
Master's/plus	4	2	2

APPENDIX J

Table 27

New Hope Covenant Group Descriptive Statistics
All Samples - Pretest Data

Descriptive	Original Sample	Mortality Sample	Research Sample
Sample Size:	23	9	14
Age: Mean	41.5	38.2	45.0
SD	10.2	10.0	10.1
Sex: Male	5	3	2
Female	18	6	12
Marital Status:			
Single	1	1	1
Married	8	3	7
Divorced	4	2	2
Remarried	4	0	2
Separated	5	3	0
Widowed	1	0	1
Cohabitation	0	0	1
Religion:			
Catholic	1	0	1
Protestant	18	7	13
Other	4	2	0
Ethnic:			
Black Af/Am.	0	0	0
Hispanic	1	0	1
White/Cauc.	22	9	13
Education:			
HS Diploma	3	2	1
Some College	12	4	8
Assoc. Degree	0	0	0
Bachelor's	5	2	3
Master's/plus	3	1	2

APPENDIX K

Table 28

Comparison Group Descriptive Statistics
All Samples - Pretest Data

Descriptive	Original Sample	Mortality Sample	Research Sample
Sample Size:	32	22	10
Age: Mean	37.0	36.8	38.8
SD	4.6	4.9	4.0
Sex: Male	16	10	6
Female	16	12	4
Marital Status:			
Single	0	0	0
Married	32	22	10
Divorced	0	0	0
Remarried	0	0	0
Separated	0	0	0
Widowed	0	0	0
Cohabitation	0	0	0
Religion:			
Catholic	0	0	0
Protestant	32	22	10
Other	0	0	0
Ethnic:			
Black Af/Am.	0	0	0
Hispanic	0	0	0
White/Cauc.	32	22	10
Education:			
HS Diploma	1	1	0
Some College	4	3	1
Assoc. Degree	2	1	1
Bachelor's	14	11	3
Master's/plus	11	6	5

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